STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. Building B. Wing	09/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lotus Village Center for Nursing & Rehabilitation	179 Combs Street Sparta, NC 28675

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37280 Based on record review, staff and Physician interviews, the facility failed to notify the Physician of medication unavailability for 1 of 1 resident (Resident #38) reviewed for pain. The finding included: Resident #38 was admitted to the facility on [DATE] with diagnoses that included degenerative joint disease and chronic pain syndrome. A review of the after visit report from the emergency department dated 09/09/22 revealed Resident #38 was seen for leg pain and diagnosed with Sciatica (nerve pain) of the left side. The report also indicated Resident #38 was given the prescription of Solumedrol 4 milligram (mg) tablets with the instruction to follow the package directions. A review of a progress note written by Nurse #1 on 09/09/22 6:25 PM revealed Resident #38 returned from the emergency department with a new script for Solumedrol 4 mg tablets and to follow the package directions. On 09/11/22 a review of Resident #38's Medication Administration Record for September 2022 revealed there was no medication listed for Solumedrol. On 09/12/22 a review of Resident #38's Medication Administration Record for September 2022 revealed the first dose of Solumedrol was given on 09/12/22 at 2:00 PM. An interview was conducted with Nurse #1 on 09/13/22 at 3:18 PM who explained that Resident #38 was sent to the emergency roiagnom on [DATE] and was diagnosed with Sciatica and returned to the facility during shift change with a prescription for Solumedrol 4 mg tablets and to follow the package directions. The Nurse continued to explain that she gave the prescription to Nurse #2 to notify the pharmacy so the medication would be delivered to the facility. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Nurse #2 on 09/13/22 at 3:34 PM the Nurse stated on Friday 09/09/22 and received report that Resident #38 had been sent to the emergency room for leg pain and returned with a prescription for Solumedrol. The Nurse continued to explain that she attempted to input the order into the system which would have been sent directly to the pharmacy and delivered in the next pharmacy run but she could not get the system to take the prescription because the script said to follow directions on the package and she had to be specific in putting the directions in the system. She stated she faxed the prescription to the pharmacy two times. The Nurse explained that the medication did not come in the pharmacy delivery that night therefore, the steroid did not get started. On 09/14/22 at 4:38 PM during an interview with Resident #38's Physician the Physician stated he was not notified of Resident #38 not receiving his ordered medication.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37280 Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessments in the areas of medications and cognition for 2 of 24 residents reviewed for MDS accuracy (Resident #58 and Resident #19). The findings include: 1. Resident #58 was admitted to the facility on [DATE] with diagnoses that included hypertension. A review of Resident #58's physician orders revealed an order dated 11/02/21 for Chlorthalidone tablet (a diuretic) give 12.5 milligrams (mg) by mouth one time a day for hypertension. A review of Resident #58's Medication Administration Record for August 2022 revealed the Resident received Chlorthalidone 12.5 mg by mouth one time a day for hypertension. A review of Resident #58's quarterly Minimum Data Set assessment with the Assessment Reference Date (ARD, the last day of the look back period) of 08/17/22 indicated the Resident did not receive a diuretic during the 7 day look back period. On 09/13/22 at 5:29 PM during an interview with the Director of Nursing (DON) she explained that the MDS Nurse who completed the 08/17/22 MDS assessment on Resident #58 was no longer employed at the facility. The DON acknowledged the miscoded MDS and stated the MDS should have reflected how many days the Resident received the diuretic. 38515 Resident #19 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease, and frontotemporal lobe dementia. A review of Resident #19's quarterly Minimum Data Set assessment dated [DATE] revealed the Brief Interview for Mental Status (BIMS, a screening tool used to assess the resident's current cognition) resident interview had not been conducted nor had the staff assessment for mental status been completed. During an interview with MDS Nurse #1 on 09/14/22 at 2:18 PM, she reported the BIMS interview was completed by the facility's social worker. She reported if the resident was unable to participate in an interview, then a staff assessment for mental status should be completed with the nurse. She explained one or the other should have been completed. During an interview with the Social Worker on 09/14/22 at 2:46 PM, she reported she had attempted to complete the BIMS interview but was unable to complete it due to Resident #19 not understanding the questions she was asking. She reported that typically, if she was unable to complete the BIMS interview, the MDS Nurse would check that the staff assessment should be completed. She explained she did not know why the staff cognitive patterns assessment had not been completed. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing on 09/14/22 at 5:54 PM, she reported either the resident interview or staff assessment for cognition should have been completed to reflect Resident #19's cognition. She explained if the social worker was unable to complete the resident interview, then the staff assessment should be completed to determine memory issues.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38515 Based on record review and staff interviews, the facility failed to update a resident's advanced directive care plan when it changed from full code status to a do not resuscitate for 1 of 2 residents reviewed for hospice (Resident #19). The findings included: Resident #19 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease, and frontotemporal lobe dementia. Review of quarterly Minimum Data Set assessment dated [DATE] revealed Resident #19 received Hospice Services. A physician order dated 3/17/22 for Do Not Resuscitate (DNR) was observed in Resident #19's record. A review of Resident #19's care plan most recently updated on 07/29/22 included: Resident #19 has an established advanced directive - full code . During an interview with MDS Nurse #1 on 09/14/22 at 2:18 PM, she reported she was responsible for reviewing and updating care plans as they changed. She reported the care plan updates would happen when there was a significant change or when a new Minimum Data Set assessment was completed. Regarding Resident #19, she reported her advanced directive care plan should have been updated by the Social Worker when the order for do not resuscitate was written. During an interview with the Social Worker on 09/17/22 at 2:46 PM, she verified she was responsible for updating advanced directive care plans when they changed. She reported she must have overlooked the change from a full code to a DNR for Resident #19. She stated the care plan should accurately reflect the most current advanced directive. During an interview with the Director of Nursing on 09/14/22 at 5:54 PM, she reported she expected care plans to be reviewed and updated as needed and at the completion of each Minimum Data Set assessment. She reported Resident #19's advanced directive care plan should accurately reflect the corresponding physician order and should not have been missed. She reported Resident #19's care plan should be updated to reflect her current advanced directive.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45359 Based on observation, record review, resident, staff, and Nurse Practitioner interview the facility failed to perform a skin assessment upon admission and failed to initiate treatment for a rash that was itching for 1 of 4 residents reviewed with skin conditions (Resident #21). Resident #21 was admitted on [DATE] with a rash that was very itchy. The rash was not treated until 07/21/22. The finding included: Resident #21 was admitted to the facility on [DATE] with diagnoses that included: congestive heart failure, diabetes, psoriatic arthritis (inflammatory arthritis) and others. Review of Resident #21's care plan initiated on 7/8/2022 revealed a care plan in place for rash on admission to upper, inner and posterior thighs, bilateral buttocks, abdominal folds and bilateral groin with interventions of redirect from scratching, administer as needed anti-itch medication initiated 8/18/2022 and was treated for scabies initiated 7/26/2022. Review of Resident #21's medical record revealed no skin assessment completed on admission. Review of an admission Minimum Data Set (MDS) dated [DATE] revealed that Resident #21 was cognitively intact and required extensive assistance with activities of daily living and no behaviors or rejection of care was noted during the assessment reference period. The MDS did not identify any open lesion other then ulcers, rashes, cuts. Review of a skin assessment dated [DATE] revealed that Resident #21 had a rash on her bilateral arms. Review of physician's orders for July 2022 revealed an order on 7/20/2022 that read; apply Permethrin Cream 5% (used to treat scabies) apply cream to entire body topically STAT (now) for scabies head to soles of feet, including neck, scalp, hairline, temple, forehead leave on for 14 hours then bathe. Review of a physician order dated 07/21/22 read; Permethrin Cream 5% apply to entire body topically one a day for scabies for 7 administrations head to soles of feet including neck, forehead, scalp, hairline and temple. Review of the Medication Administration dated July 2022 revealed that Resident #21 received the Permethrin cream as ordered on 07/21/22, 07/23/22, 07/24/22, 07/25/22, 07/26/22, and 07/27/22. An observation and interview were conducted with Resident #21 on 9/11/2022 at 3:47 PM. Resident #21 stated she was admitted to the facility on [DATE] with skin sores on her bilateral arms, legs, chest, bilateral legs, back and buttocks. She revealed she had scabies before but could not remember the date. Resident #21 stated she just thought she might have come in contact with something she was allergic to at the hospital, since her Cardiologist told her it was not scabies, but an allergic reaction to something. She indicated it was very itchy and she kept scratching the sores. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted with Nurse Aide (NA) #5 on 9/13/2022 at 4:21 pm. NA #5 stated she was assigned to 100 hall and took care of Resident #21 upon her admission on 07/08/22. She revealed Resident #21 was admitted to the facility with a rash all over her. She stated the Nurse Practitioner was here when Resident #21 was admitted and came to assess Resident #21's rash. NA #5 revealed Resident #21 was on contact precautions because we were told she had a bad bug in her urine, so we were only wearing personal protective equipment (PPE) to empty her urinary catheter. NA #5 stated that the first time she was aware that Resident #21 was ordered a cream for her rash was on 07/23/22. The Nurse applied cream to Resident #21's entire body on Saturday, 7/23/2022, and the Nurse told me that it would need to be washed off after 24 hours. NA #5 stated she gave Resident #21 a bath on Sunday, 7/24/2022. An observation and interview of Resident #21 was made on 09/13/22 at 5:27 PM. Resident #21 was up in chair at the nursing station. She stated that this was her first time up and out of her room since admission. She was dressed in long pants and short sleeve shirt. Resident #21's bilateral arms were covered with small irregular scabs that were approximately the size of pencil eraser. They were well defined, and each area was scabbed over. There was no redness or erythema or drainage and were not crusted. Resident #21 indicated that her arms looked better than they have in a long time. The Nurse Supervisor was interviewed on 9/14/2022 at 10:16 AM. The Nurse Supervisor stated that each resident upon admission was supposed to have a head-to-toe assessment including their skin. Once the admission nurse completed the assessment then the night shift nurse was supposed to check and ensure all the components of the admission were completed then the Director of Nursing (DON) would do the final check to ensure all components of the admission were completed. The Nurse Supervisor stated she did not know who was supposed to completed Resident #21's admission assessment and could not speak to how the checks and balances were not done to ensure the admission skin assessment was completed and treatment for identified issues started. An interview was conducted with Medication Aide (MA) #2 on 09/14/22 at 2:00 PM who confirmed she was working on the hall when Resident #21 was admitted to the facility. She confirmed that she did not do treatments or any form of skin assessment that would be up the Nurse Supervisor and she could not recall who was the nurse was that day. MA #2 stated that she assisted Resident #21 on the bed pan on 07/08/22 and noted that she had open lesions all over her body that looked like bites or bug bites. MA #2 stated that she told a nurse but could not recall who that was but recalled being told it looked like something she was allergic to probably from the hospital. She stated she did not think that was right and couple of week later learned that it was scabies. The DON was interviewed on 9/14/2022 at 2:24 PM. DON stated she was on vacation when Resident #21 was admitted to the facility, from 7/8/2022 through 7/16/2022, so she was unaware that Resident #21's admission assessments, to include a skin assessment, had not been completed or why treatment to identified areas had not been initiated sooner. DON revealed she was supposed to have daily clinical meetings to talk about resident findings and concerns, this team is supposed to made up of the DON, Social Worker, MDS, Nurse Supervisor, Assistant Director of Nursing and Therapy, but right now the clinical team consisted of the DON and Nurse Supervisor and at lot of time the Nurse Supervisor was being pulled to the hall due to staffing challenges. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The Nurse Practitioner was interviewed on 06/14/22 at 6:29 PM. The NP confirmed that she had seen and evaluated Resident #21 upon her admission to the facility on [DATE] and suspected scabies by the crusted lesion she had on her arms and legs. The Nurse Practitioner stated that she had ordered Triamcinolone cream for the itching and Permethrin cream for the scabies but later learned that she did not enter a date and time on the order, so the order never got carried out and the medication never got applied until it was again ordered on 07/20/22. The Nurse Practitioner also stated she was unaware until 07/20/22 that her initial order never got carried out by staff.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45359 Based on observations, record review, staff, Nurse Practitioner, and Medical Director interviews the facility failed to provide wound treatments per the hospital discharge summary for 5 days and to complete or document a skin assessment on admission for 1 of 3 residents reviewed for pressure ulcers (Resident #21). The findings included: Resident #21 was admitted to the facility on [DATE]. Her diagnoses included combined systolic and diastolic (congestive) heart failure, and type 2 diabetes with neuropathy. Review of the hospital discharge summary dated 7/8/2022 at revealed bilateral heel wound orders: 1. Left foot: Topical dressing: wet to dry gauze with Dakin's (contains sodium hypochlorite, used as an antiseptic to cleanse wounds in order to prevent infections), to be changed 2 times a day, wash with soap and water in between dressing changes. Recommend collagenase (enzymes that break down the native collagen that holds animal tissues together) to right leg ulcer with eschar, compression therapy (edema wear), offloading of heels and non-weight bearing, calf-ankle exercises, and follow-up with wound care. 2. Right foot: twice daily dressing changes: apply barrier cream to wound border/peri-wound, then apply a dampened Dakin's kerlix to the wound bed, cover with a pad, kerlix and ace bandage (starting from below toes to below knee). 3. Follow-up appointment at Wound Care Center on 7/25/2022 at 9:15 AM. Review of the electronic record revealed the Nurse Practitioner entered the order to follow the hospital discharge wound orders on 7/8/2022 at 4:22 PM and it was confirmed by the Nurse Supervisor. An interview was conducted with the Nurse Practitioner (NP) on 9/14/2022 at 6:14 PM. NP stated she no longer worked at the facility and her last day was 8/19/2022. She stated she was familiar with Resident #21 and that she was admitted to the facility with bilateral wounds on her heels. NP revealed she had been present at the time of Resident #21's admission to the facility and had assessed her at that time. NP stated she entered the wound treatment orders and forgot to enter the time and date to start the treatments. An interview was conducted with Nurse Supervisor on 9/14/2022 at 10:17 AM. She stated on Resident #21's admission to the facility, she confirmed and entered the orders into the electronic medical record. She revealed she thought she had reviewed the orders before confirming and stated she must have made a mistake on the wound orders and did not make sure they had a time and date to start. The Nurse Supervisor stated she had no knowledge that Resident #21's pressure ulcers on her bilateral heels did not have treatment orders from 7/8/2022 through 7/13/2022. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the admission Minimum Data Set (MDS) dated [DATE] revealed Resident #21 was cognitively intact and required extensive to total assistance with activities of daily living (ADL). She was coded as an extensive assistance for bed mobility. Resident #21 was coded for 2 unstageable pressure ulcers. Review of Resident #21's care plan revealed she had a care plan in place for admission with bilateral heel pressure ulcers initiated on 7/8/2022, with intervention of provide wound treatments as ordered initiated on 7/15/2022. Review of Resident #21's Treatment Administration Record for July 2022 revealed there were no wound orders entered prior to 7/14/2022: 1. Order dated 7/14/2022 with a stop date of 7/22/2022: Collagenase (enzymes that break down the native collagen that holds animal tissues together) ointment 250 milligrams/unit (mg/u), apply to left heel topically every night shift, cleanse heel with normal saline, apply a nickel layer of collagenase to slough tissue, cover with a pad and wrap with kerlix every night shift. 2. Order dated 7/22/2022 with a stop date of 8/29/2022: Collagenase ointment 250mg/u apply to bilateral heels topically every night shift for wound care, cleanse heels with normal saline, apply a nickel thick layer of collagenase to slough tissue, cover with a pad and wrap with kerlix wrap every night shift and as needed. Observation of Resident #21's wound care on 9/13/2022 at 2:12 PM revealed Nurse #5 explained to Resident #21 what treatments she was going to perform to her bilateral heels. Nurse #5 followed infection control principles and completed wound treatments to bilateral heels as per medical provider orders. The bilateral heel wounds were without drainage or odor, edges of wounds clean, wound beds pink, no necrotic tissue noted. Resident stated she had been to the wound center on 9/12/2022 for wound debridement. An interview was conducted on 9/14/2022 at 1:34PM by telephone with Nurse #7. She stated she worked at the facility through an Agency and had been assigned as the Nurse on 7/22/2022 for 7 PM-7 AM shift for 100 hall. Nurse #7 revealed she had not worked at the facility for last 3 weeks. She revealed she was familiar with Resident #21 and had taken care of her since her admission to the facility. Nurse #7 revealed Resident #21 was admitted with bilateral wounds on her heels. She stated the Nurse was responsible for completing any treatments ordered for the resident and then document the completion on the Treatment Administration Record (TAR). She stated she was not aware that treatments had been missed for Resident #21. She stated Resident #21 had not voiced any concerns to her. Nurse #7 stated she documented completion of treatments as soon as she completed them, because it was very busy at night and if you didn ' t ' t take the time to document, then you might forget to document at all. She stated she would notify the Director of Nursing is she had any concerns regarding wound care and treatments. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Director of Nursing (DON) on 9/14/2022 at 2:14 PM. The DON stated she was familiar with Resident #21 and noted she was admitted to the facility with bilateral wounds on her heels. DON revealed she had not checked on TAR completion because it was only her and one other Administrative Nurse to review and complete all the nurse administration jobs. The DON revealed she did not know why Resident #21 did not have a skin assessment completed on admission or how she did not have treatment orders. The DON indicated part of the admission process was to make sure that all orders are entered correctly into the electronic record and that all assessments are completed within 24 hours and to report to her that the admission process was completed within 24 hours and staff to notify her if unable to complete. A telephone interview was conducted with the Medical Director (MD) on 9/14/2022 at 4:16PM: He stated he was familiar with Resident #21. MD stated he was not aware that Resident #21's treatments had not been completed. MD stated he expected staff to complete orders as prescribed and if unable to complete orders, then to notify him or the Nurse Practitioner.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45359 Based on observations, record review, staff, Nurse Practitioner, and Medical Director interviews the facility failed to apply splints for 1 of 1 resident reviewed for range of motion (Resident #9). The findings included: Resident #9 was admitted to the facility on [DATE]. Her diagnoses included anoxic brain injury, and chronic obstructive pulmonary disease. Review of the hospital discharge summary dated 3/23/2022 revealed Resident #9 had a diagnosis of contractures of the hands, that were not present on admission to the hospital. Discharge order: bilateral soft wrist splints. Review of the most recent quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #9 was cognitively intact and was totally dependent on staff for activities of daily living (ADLs). Range of motion was not coded. Review of Resident #9's care plan initiated on 7/11/2022 revealed a care plan for splint application by restorative nursing, to apply bilateral palm splint for 8 hours a day, every day. Observations of Resident #9 throughout the survey revealed the following: 9/11/2022 at 11:25AM revealed Resident #9's hands, lying on top of covers, had bilateral hand contractures without bilateral palm splint in place. 9/11/2022 at 2:58PM no bilateral palm splints in place. 9/12/2022 at 9:07AM observation of Resident #9, bilateral hands located on top of covers with no bilateral palm splints in place. 9/12/2022 at 3:10PM no bilateral palm splints in place. 9/13/2022 at 9:03AM observation of Resident #9 revealed bilateral hands outside of covers and no bilateral palm splints in place. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview conducted with Nurse #1 on 9/13/2022 at 9:11 AM revealed she was the hall nurse responsible for Resident #9. She stated she was aware that Resident #9 had bilateral hand contractures but was not sure if she was supposed to wear splints. She indicated she was going to review the order. Nurse #1 reviewed Resident #9's orders and reported that Resident #9 was supposed to be wearing bilateral palm splints for 8 hours a day, on day shift, she further revealed that Resident #9 should of already had the splints applied, and that she would apply them. Nurse #1 stated if a resident had an order for splint application, then staff should follow the orders, if they are not able to apply the splints, then the Director of Nursing should be notified. Nurse #1 indicated there was no restorative nursing at the facility, therefore the Nurse Aides or the Nurse were responsible for applying the splints. An interview was conducted with Nurse Aide (NA) #1 on 9/13/2022 at 10:32 AM. NA #1 stated she was an Agency NA. She revealed she was not familiar with Resident #9 and had only been at the facility for a couple of days. She stated she was supposed to check the Resident's Kardex to find out what kind of care a resident needed. NA #1 revealed she did not check the Kardex prior to taking care of Resident #9 and that she and NA #2 had been working together to complete the work on the hall. NA #1 indicated she had not reviewed the Kardex because there were so many residents on the hall (300 hall) and their call bells rang constantly, so she was just doing the best she could. NA #1 stated she should have reviewed the Kardex, and that Resident #9 should have had bilateral palm guards applied. An interview was conducted with NA #2 on 9/13/2022 at 1O:33 AM. She stated she was an Agency NA. She revealed she was working with NA #1 on 300 hall to get the work completed. NA #2 stated she was not aware that Resident #9 was supposed to be wearing bilateral palm guards. NA #2 revealed she had received report from the previous shift this morning, but there was no mention of splints. She stated she should have checked the Kardex to see what kind of care Resident #9 needed, but she did not, she stated she was too busy to check the Kardex. NA #2 indicated she was doing the best she could do and would remember to check the Kardex the next time. NA #2 stated to her knowledge there was no restorative nursing and NAs should apply the splints. An interview was conducted with the Certified Occupational Therapy Assistant (COTA) on 9/13/2022 at 11:32 AM. The COTA revealed she had been at the facility for 3 years and she was familiar with Resident #9. She stated the facility did not have a restorative nursing program and had not had one for several years. The COTA indicated Resident #9 had an order for bilateral palm splints to be applied for 8 hours every day. She stated the facility had a lot of traveling Nurse Aides and they should review the Kardex prior to taking care of a resident to see what kind of care that resident needed. The COTA stated she had gone down to assess Resident #9 and found her bilateral palm guards on. She stated she educated the 2 traveling NAs (NA #1 and NA #2) on 9/13/2022 on how to apply the splints correctly and for how long the splints were to remain on, when she realized the splints had not been applied. The COTA revealed the Occupational Therapist is only in the facility 2 days a week, but she left a treatment plan with goals for the COTA to follow, to treat those residents on her caseload. She stated since the facility did not have a restorative nursing program, the staff on the hall were responsible for the splint application. She indicated when a resident came off Occupational Therapy for splints, the Therapy Department initially educated the hall staff on the application of the splint and how to remove the splint, after that, any new staff or Agency staff were trained by the nursing department. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Nurse Supervisor was interviewed on 9/14/2022 at 10:17 AM. She stated she was familiar with Resident #9. Nurse Supervisor revealed Resident #9 did have an order for hand splints. She indicated Resident #9 had previously been on Physical Therapy caseload when she was first admitted to the facility. Nurse Supervisor revealed she was concerned that Resident #9's hand contractures had gotten worse, and she had put in an order for Physical Therapy to screen Resident #9, Physical Therapy did not pick Resident #9 up for therapy and Nurse Supervisor was advised that Resident #9 did not have contractures, but her hands had just stiffened. She stated she did not remember when she had put in the request for an evaluation by Physical Therapy, but it had been in the past couple of months. Nurse Supervisor stated if a resident had an order for splint application, then staff should apply the splints as ordered. She indicated the facility did not have a restorative nursing program, so hall staff was supposed to apply the splints. She stated the nursing department was trained by the Therapy Department on how to apply splints and how to remove splints for an individual resident when the resident came off therapy. Nurse Supervisor stated the nursing department was responsible for training any staff that did not have the initial training. An interview was conducted with the Director of Nursing (DON) on 9/14/2022 at 2:25 PM. The DON stated she was familiar with Resident #9. She stated Resident #9 had an order for bilateral palm splints to be applied every day for 8 hours on day shift. DON revealed the facility did not have a restorative nurse program, therefore, staff on the hall assigned to Resident #9 was responsible for making sure the splints had been applied. The DON revealed the Therapy Department did the initial training for splint application and removal, nursing staff had annual training on competencies and on hire. The DON stated her expectation was for staff to follow all orders and if they were unable to apply the splints to notify the Nurse on the hall or herself. A telephone interview as conducted with the former Nurse Practitioner (NP) on 9/14/2022 at 6:29 PM. She stated her last day at the facility was 8/19/2022. The NP stated she was familiar with Resident #9 and that she had bilateral hand contractures. She indicated that Resident #9 had orders for bilateral hand splint application and hall staff was responsible for splint application. NP stated Resident #9's bilateral hand splints should have been applied as ordered and that by not having the splints applied could make the contractures worse. The NP stated her expectation was for orders to be followed as written, and if the order could not be followed then she should have been notified, and she had not been made aware that the splints had not been applied. She further revealed she expected the Occupational Therapist to conduct another evaluation to determine if the contractures had deteriorated and to treat if indicated. A telephone interview was conducted with the Medical Director. He stated he was familiar with Resident #9. He stated his expectation was for staff to follow physician orders as written and to notify himself or the NP if the order could not be followed. Medical Director revealed that contractures could worsen if splints were not applied.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38515 Based on record review, facility staff interviews, the facility failed to provide care in a safe manner for 1 of 4 residents reviewed for accidents. The resident rolled out of bed during care and sustained a laceration above his eye along with contusions to his head, skin tear to left elbow and a skin tear just above the left wrist (Resident #33). The findings included: Resident #33 was admitted to the facility on [DATE] with diagnoses that included contracture and poly-osteoarthritis. Review of Resident #33's most recent annual Minimum Data Set assessment dated [DATE] revealed him to be severely impaired with no behaviors or rejection of care. He required total assistance of 2 or more with bed mobility, transfer, dressing, personal hygiene, and bathing. He required extensive assistance of 2 or more with toilet use. A review of Resident #33's progress notes revealed a progress note dated 6/18/22 at 4:47 AM and was written by Nurse #3. The note documented at approximately 12:45 AM, the nurse was called to Resident #33's room by the Nursing Assistant (NA). Upon entering the room, the nurse observed the resident lying on the floor, face down. The resident's mouth, nose, and face were found to be actively bleeding. After checking for injuries, the resident was rolled over onto side to and the resident had an approximate 1.5 centimeter (cm) laceration just above his left eye. There was also a skin tear to left elbow and a skin tear just above his left wrist. The nurse applied pressure to left eye to control the bleeding while another nurse called 911 for emergency transport. The resident was sent to emergency room (ER) and received stitches above the left eye and steri-strips to the left elbow. The resident returned was documented as having returned to the facility in stable condition. Review of Resident #33's hospital notes dated 6/18/22 from his visit post fall revealed he was treated for a 1. 5 cm laceration above the left eye between the eyebrow and eyelid. The notes indicated 3 sutures (stitches) were completed with no complications. Other injuries noted in the hospital report included a contusion (bruise) to Resident #33's left knee and shoulder, a contusion on his head, a cervical strain, and abrasions and skin tears. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	An interview with Nurse Aide (NA) #6 on 9/13/22 at 4:00 PM, she reported she remembered the night Resident #33 fell out of bed on 6/18/22. She stated it was her first night working and on her 2nd round, she went into Resident #33's room and noticed he had vomited on himself and had some diarrhea. She reported after she changed him and had removed his dirty sheets, she rolled him on his side to put on clean sheets and when she went to apply the corner of the fitted sheet over the corner of his mattress, Resident #33 rolled out of bed towards her and face down onto the floor. She reported she believed he hit his head, elbow, and side. NA #6 verified it was just her in the room during care and that she was under the impression from the NA she received report from that Resident #33 was a one person assist. She stated she did not verify his care status with the nurse or in the electronic system. NA #6 detailed that Resident #33 was bleeding from his head, so she went and got the hall nurse immediately who assessed the resident and began first aid while another staff member contacted 911. During an interview with Nurse #3 on 9/14/22 at 4:45 PM, she reported she remembered the night Resident #33 fell on [DATE]. She stated she was on the hall when NA #6 came and got her and stated Resident #33 had fallen from the bed while she was providing care. Nurse #3 stated she went to the room and noticed he was bleeding from his head and was face down on the floor. After she assessed him, they rolled him over and she noted a laceration above Resident #33's eye that looked like it would need stitches. 911 was called and resident was sent to the emergency room for treatment and evaluation. She reported she believed he returned shortly after with stitches and other bandages from various skin tears. A review of the facility ' s fall investigation dated 6/18/22 and completed by Nurse #3, revealed Resident #33 was being cleaned up from vomiting just before incident occurred, was turned to his side to prevent aspiration if vomiting should occur again, NA (Nurse Aide) #6 was reaching for a clean sheet when resident rolled onto the floor. Per the investigation, there was only one staff member in the room at the time and attempted to change the bed sheets when Resident #33 fell from the bed. During an interview with the Director of Nursing on 09/14/22 at 5:54 PM, she reported she was aware of the incident and reported staff should verify care needs by looking at the electronic system. The DON indicated NA #6 received training to verify care status before providing care to all residents on her assignment. She stated all staff should verify care needs daily before their shift to ensure they knew how many staff members would be needed to safely provide care. She reported if Resident #33 was coded as requiring 2 or more persons to assist with bathing, dressing, toilet use, and personal hygiene, then there should have been at least two staff members in the room the night he fell out of the bed.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38515 Based on observations, record review, and facility staff interviews, the facility failed to ensure a resident's urinary catheter tubing and drainage bag did not come into contact with the floor for 1 of 3 residents reviewed for catheters (Resident #33). The findings included: Resident #33 was admitted to the facility on [DATE] with diagnoses that included neuromuscular dysfunction of bladder. A review of Resident #33's annual Minimum Data Set assessment dated [DATE] revealed him to be severely impaired. He was coded as having a catheter. Review of Resident #33's care plans last reviewed on 08/02/22 revealed a care plan for Resident #33 that required an indwelling (supra-pubic) catheter due to: neurogenic bladder. Interventions included: keep catheter off floor. An observation of Resident #33 in his room completed on 09/12/22 at 9:22 AM revealed his catheter tubing and catheter bag to be laying on the floor beside his bed. An interview with Nurse Aide #3 (NA#3) on 09/12/22 at 9:27 AM revealed she did not know why the catheter bag was on the floor and she reported it should not be in contact with the floor at any time. She proceeded to adjust the catheter bag and the tubing to where it was no longer in contact with the floor. NA #3 reported it was the responsibility of all floor staff to ensure catheter bags and tubes were off the floor. Another observation completed on 09/13/22 at 2:21 PM revealed Resident #33 to be in his bed resting, his catheter tubing was observed to be lying in the floor. During an interview with Nurse #4 on 09/13/22 at 2:31 PM, she reported that catheter bags and tubing should not encounter the floor. She reported she believed it was the responsibility of the nurse aides when they provided care to make sure the catheter tubing was off the floor. She reported she would adjust the tubing and the bed to make sure it was no longer touching the floor. An additional observation completed on 09/14/22 at 10:55 AM revealed Resident #33's catheter tubing to lay on the floor beside his bed During an interview with the Director on Nursing on 09/14/22 at 11:00 AM, she verified that catheter bags and tubing should not touch the floor. She reported it was the responsibility of all the staff to ensure catheter bags and tubing did not rest on the floor. She reported she expected catheter tubing and bags to stay off the floor to prevent possible contamination.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38515 Based on observations, record review and staff interviews, the facility failed to keep air filters on oxygen concentrators clean and free from dust buildup for 1 of 3 residents reviewed for respiratory care. (Resident #24) The findings included A review of the facility's policy titled Oxygen: Concentrator last revised on 06/01/21 revealed the following instructions: 14. Perform maintenance according to manufacturer's instructions and by approved preventative maintenance personnel . 14.2 clean the intake filter. Resident #24 was admitted to the facility on [DATE] with diagnoses that included COVID-19, shortness of breath, and solitary pulmonary nodule (a single mass in the lung). Review of Resident #24's significant change Minimum Data Set assessment dated [DATE] revealed him to be severely impaired and having received oxygen therapy while a resident. A review of Resident #24's physician orders revealed an order dated 04/10/22 to clean external filter on oxygen concentrator. Another order dated 04/04/22 was for oxygen at 2 liters per minute via nasal canula as needed for shortness of breath, exertional dyspnea, or oxygen saturation levels below 90%. An observation of Resident #24's oxygen concentrator on 09/12/22 at 9:08 AM revealed the filter to be caked with white dust particles. The oxygen concentrator was running at the time of the observation. Another observation completed on 09/13/22 at 2:33 PM revealed the oxygen concentrator to be in the same condition as the day before with the filter caked with white dust particles. A third observation completed on 09/14/22 at 9:08 AM revealed Resident #24's oxygen concentrator to be in the same condition as the previous two days, with the filter caked with thick white dust particles. An interview with Nurse Aide #4 on 09/14/22 at 9:10 AM revealed she was an agency nurse aide and did not know who was responsible for cleaning the filters on the oxygen concentrators. She reported she had been at the facility several weeks and she had never cleaned any oxygen filters, nor had she ever been told it was her responsibility. During an interview with Nurse #3 who was assigned to Resident #24 on 09/14/22 at 9:14 AM, she reported she did not know who was responsible for cleaning oxygen concentrator filters. She reported she had never cleaned or changed a dirty oxygen concentrator filter. Nurse #3 verified she was a routine nurse on Resident 24's hall. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with Nurse Supervisor #1 on 09/14/22 at 9:25 AM, she reported oxygen concentrator filters should be cleaned when the oxygen tubing and nasal cannulas were changed out. She reported the condition of Resident #24's oxygen concentrator filter was unacceptable and probably had not been cleaned in several weeks. She reported she would change the filter. During an interview with the Director of Nursing 09/14/22 at 5:54 PM, she reported oxygen concentrator filters should be changed weekly with the tubing and nasal cannulas. She reported she was informed by Nurse Supervisor #1 about the condition of Resident #24's oxygen concentrator filter and that it should have been changed before getting to that condition.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42090 Based on record reviews and staff interviews, the facility failed to ensure physician visits were performed every 60 days as required for 4 of 4 residents reviewed for physician visits (Resident #73, Resident #75, and Resident #33). Findings included: 1. Resident #73 was admitted to the facility on [DATE] with diagnosis that included frontotemporal dementia, Alzheimer's disease, and recently diagnosed on [DATE] with COVID-19. A quarterly MDS dated [DATE] indicated Resident #73 was cognitively impaired. A review of the EMR revealed Resident #73 was seen by MD #2 for an acute problem visit on 11/15/21. It further indicated Resident #73 had not been seen by the physician (MD#1) or Nurse Practitioner (NP) for a routine regulatory visit in the facility since November 2021. Resident #73 was only seen for acute problem visits by the NP on 5/18/22 and 7/8/22. 2. Resident #75 was admitted to the facility on [DATE] with diagnosis that included diabetes, peripheral vascular disease, and epilepsy with a recent re-admitted d 6/25/22 after a hospitalization for diabetic ketoacidosis and pneumonia. A Significant Change MDS dated [DATE] indicated Resident #75 was moderately impaired for cognition. A review of the EMR revealed Resident #75 had not been seen by a MD or NP for a routine regulatory visit since re-admission. The record further indicated Resident #75 was only seen for acute problem visits by the NP on 5/24/22, 6/1/22, 6/2/22, 6/7/22, 6/8/22, 6/9/22, and 6/29/22. 3. Resident #33 was admitted to the facility on [DATE] with diagnosis that included diabetes, chronic pain, and recent readmission following a hospitalization for a fall with pain and a left upper eyelid laceration and a second hospitalization for sepsis secondary to cellulitis of the lower extremity. An Annual MDS dated [DATE] indicated Resident #33 was severely cognitively impaired. A review of the EMR revealed Resident #33 revealed had been seen by MD #2 for an acute problem visit on 2/21/22. It further indicated he had not been seen by a MD or NP for a routine regulatory visit in the facility since February 2022. It indicated Resident #33 had been seen by the NP for acute problem visits on 6/1/22, 6/17/22, and 7/8/22. An interview with the Business Office Manager (BOM) on 09/14/22 at 10:50 AM revealed she prepared a list for MD #1 of residents who needed to be seen for certification regulatory visits required for Medicare payments only; however, she was not involved in preparation of a list of routinely required visits or the notes returned to the facility following visits by MD #1. The BOM indicated these duties would be handled by the Medical Records Director and she was unaware of exactly how many residents had not yet been seen by MD #1 since he started as the Interim Medical Director in April 2022. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the Director of Nursing (DON) on 9/14/22 at 10:57 AM revealed she has been the DON since January 2022. She indicated the facility's former Medical Director (MD #2) had retired from the facility in April 2022. Since that time, the facility had in place an Interim Medical Director (MD #1) who lived over 3 hours away from the facility and she was aware he had not been able to see each resident as required in the facility for routine regulatory visits since he took over. The DON stated the facility attempted to collaborate between herself, BOM, and the Medical Records Director to provide MD #1 a list of residents in the facility that must be seen with priority. The DON elaborated to say the Medical Records Director had not provided her a list of residents who had not been seen by MD #1; however, she was aware there were concerns that residents had not been seen in a timely manner according to regulatory requirements. An interview with the Medical Records Director on 09/14/22 at 11:03 AM revealed she has been the Medical Records Director since January 2022. She indicated she was aware MD #1 had not seen all residents for routine regulatory visits since he took over as Interim Medical Director when MD #2 retired in April 2022. The Medical Records Director stated she was told to print a list of who MD #1 needed to see, but she had only witnessed MD #1 being in the facility to see patients on one occasion since he started which was in July 2022, but she could not recall the exact date. An interview with the Administrator on 09/14/22 at 2:53 PM revealed he had been made aware of concerns that MD #1 had not seen residents as he should.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 35789 Based on record review and staff interview the facility failed to ensure there was a Registered Nurse (RN) scheduled for at least 8 consecutive hours per day for 15 days out of the last 60 days reviewed (07/15/22, 07/19/22, 07/20/22, 07/25/22, 07/28/22, 07/29/22, 08/07/22, 08/08/22, 08/14/22, 08/17/22, 08/18/22, 08/22/22, 09/01/22, 09/02/22, and 09/04/22.) The findings included: A review of the daily assignment sheet for the last 60 days was made along with the Scheduling Coordinator on 09/13/22 and 09/14/22. The review revealed that there was no RN scheduled for at least 8 consecutive hours on the following days: 07/15/22, 07/19/22, 07/20/22, 07/25/22, 07/28/22, 07/29/22, 08/07/22, 08/08/22, 08/14/22, 08/17/22, 08/18/22, 08/22/22, 09/01/22, 09/02/22, and 09/04/22. The Scheduling Coordinator was interviewed on 09/13/22 at 11:31 AM who confirmed that she scheduled the nursing staff in the facility. She stated that she did not have a RN at least 8 consecutive hours every day. The Scheduling Coordinator stated that she tried have a RN in the building each day but with the agency staff that was not always possible. She further confirmed that she was actively recruiting for additional RNs to help with the coverage. The Director of Nursing (DON) was interviewed on 09/14/22 at 2:24 PM. The DON confirmed that she was aware she did not have a RN for 8 consecutive hours each day. She stated that her RN supervisor had worked several weeks in a row and needed some time off. The DON stated most of her staff were agency and she took what staff she could get and sometimes there was no RN coverage in the building. The DON stated they were actively recruiting for additional staff specifically a RN. The Administrator was interviewed on 09/14/22 at 3:45 PM. The Administrator he had only been at the facility for about 3 weeks and he expected there to be a RN in the building at least 8 consecutive hours each day.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37280 Based on record review, staff, Resident, Pharmacy Manager and Nurse Practitioner interviews, the facility failed to prevent a significant medication error when they failed to obtain and administrator a steroid medication as ordered by the physician for 1 of 2 residents reviewed for pain (Resident #38). The finding included: Resident #38 was admitted to the facility on [DATE] with diagnoses that included degenerative joint disease and chronic pain syndrome. A review of Resident #38's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact and received scheduled and as needed pain medication in the last five days of the assessment reference date (ARD). The MDS also indicated the Resident received opioids 5 days of the 7 day look back period. A review of a progress note written by Nurse #1 on 09/09/22 at 2:09 PM revealed Resident #38 complained of increased throbbing pain to his left lower leg and insisted on going to the hospital. The on call service was notified and gave an order to send to the emergency room . A review of the after visit report from the emergency department dated 09/09/22 revealed Resident #38 was seen for leg pain and diagnosed with Sciatica (nerve pain) of the left side. The report indicated the Resident was given Tylenol (for pain) and Solumedrol (a steroid) while in the emergency department. The report also indicated Resident #38 was given the prescription of methylprednisolone 4 milligram (mg) tablets with the instruction to follow the package directions. A review of a progress note written by Nurse #1 on 09/09/22 6:25 PM revealed the Resident returned from the emergency room with a new script for Solumedrol 4 mg tablets and to follow the package directions. The Resident was in bed and continued to complain of pain and wanted to know when the shot of steroid would start to work. He was educated on medications and verbalized understanding. On 09/11/22 a review of Resident #38's Medication Administration Record for September 2022 revealed there was no medication listed for the steroid Solumedrol. On 09/12/22 a review of Resident #38's Medication Administration Record for September 2022 revealed an order for Solumedrol tablet 4 mg, give one tablet by mouth one time a day for moderate pain. Follow tapering dosage on package, change order to reflect. Start date 09/12/22 at 2:00 PM. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/11/22 at 3:13 PM an interview was conducted with Resident #38. The Resident explained that he went to the emergency roiagnom on Friday September 09, 2022 for pain in his left leg and was diagnosed with Sciatica. The Resident continued to explain that he was given a steroid shot and a prescription for the steroids to continue for a few days, but he had not received the steroid medication. He stated the nurse (he did not know which one) told him that they could not get the medication over the weekend because the faxes did not work. The Resident stated the steroid shot they gave him in the emergency room had worn off and they tried to give him narcotics, but he did not take narcotics. He stated the Tylenol helps a little. The Resident remarked he did not see why the facility could not get his medication when the doctor ordered it to be given to him. An interview was conducted with the Supervisor on 09/12/22 at 9:16 AM who was also the Nurse who cared for Resident #38 on 09/11/22 from 7:00 AM to 7:00 PM. The Supervisor was asked about Resident #38's visit to the emergency roiagnom on [DATE] and the order for the steroid medication. The Supervisor explained that she did not know about the emergency room visit or new medication being ordered until the Surveyor asked about it. The Supervisor looked through a stack of papers on the desk and found a prescription for Solumedrol 4 mg tablets (21 tablets) and to follow the package directions. The Supervisor also found where the prescription had been faxed to the pharmacy on 09/10/22 at 12:04 AM and 12:05 AM both with the confirmation of no answer for the faxed prescription. The Supervisor explained that the nurse who faxed the prescription to the pharmacy should have called the pharmacy and received verbal confirmation of receiving the prescription so the Resident could have been given the mediation as ordered and without delay. The Nurse continued to explain that the Resident did not complain of pain when she worked with him on 09/11/22 nor did the Resident report to her about the emergency room visit or the new medication. On 09/12/22 at 10 AM the Supervisor provided a faxed confirmation dated 09/12/22 9:45 AM of Resident #38's Solumedrol prescription being sent to the pharmacy. Attached to the confirmation was the prescription for Resident #38's Solumedrol dated 09/10/22 at 6:54 AM with the result of that no answer. On 09/13/22 at 11:07 AM an interview with the Pharmacy Manager (PM) revealed, the pharmacy delivery occurred once on Sunday and twice a day Monday through Saturday at times of approximately 4:35 PM and 1:05 AM. The PM explained that when the nurses input the orders into the system the order will directly be transmitted to the pharmacy and the medication would be delivered in the next delivery scheduled for the facility. She continued to explain that the nurses could also fax or telephone the orders directly to the pharmacy both of which would be received 24 hours a day 7 days a week. The PM continued to explain that the pharmacy closed at 5:00 PM but the phone call would roll over to an after hour service and the pharmacy had a stat service they could utilize within 4 hours so there was no reason why the Resident should have missed his medication. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with Nurse #1 on 09/13/22 at 3:18 PM who explained that on the afternoon of Friday 09/09/22 Resident #38 complained of pain in his left leg but refused to take his prescribed Tramadol for the pain citing he did not take narcotics. The Resident insisted on being sent to the emergency room , so she notified the on call service and got an order to send him to the emergency room . The Nurse continued to explain that when the Resident returned to the facility, she learned that they diagnosed him with Sciatica and gave him a steroid injection and sent a prescription of more steroids to continue at the facility. The Nurse reported he returned from the emergency room around shift change so she gave the prescription to Nurse #2 who was relieving her from duty. Nurse #1 explained that Nurse #2 attempted to input the new prescription in the computer system which would have been immediately transmitted to the pharmacy and sent in the next pharmacy delivery but since the prescription was not specific to the dose and times she faxed the prescription to the pharmacy. The Nurse stated it was not until she came on duty the next day that she realized Resident #38's medication was not at the facility. She stated on Saturday the Resident did complain of left leg pain but stated it was not as bad as it was on Friday and was agreeable to taking the Tramadol for the pain which was effective. The Nurse stated she did not call the pharmacy about the medication because she thought the medication would be delivered during her shift but there was no pharmacy delivery during her shift that day. The Nurse explained that she did not pass on in report to Nurse #3 that Resident #38's medication had not come from the pharmacy because she was so busy that she forgot. On 09/14/22 2:01 PM Nurse #1 explained that she witnessed Nurse #2 fax Resident #38's prescription to the pharmacy on the morning of 09/10/22 during the shift change report. During an interview with Nurse #2 on 09/13/22 at 3:34 PM the Nurse stated she was an agency Nurse that worked 3-4 days a week on the 7:00 PM to 7:00 AM shift. The Nurse explained that she relieved Nurse #1 on Friday 09/09/22 and received report that Resident #38 had been sent to the emergency room for leg pain and returned with a prescription for Solumedrol. The Nurse continued to explain that she attempted to input the order into the system which would have been sent directly to the pharmacy and delivered in the next pharmacy delivery but she could not get the system to take the prescription because the script said to follow directions on the package and she had to be specific in putting the directions in the system. She stated she faxed the prescription to the pharmacy two times. The Nurse explained that the medication did not come in the pharmacy delivery that night. The Nurse continued to explain that when Nurse #1 came on duty the next morning (09/10/22) she told the Nurse that she could not complete the order in the system, so she faxed it again that morning. She stated she did not know if it went through to the pharmacy or not but did not think about calling the pharmacy directly. Numerous attempts were made to interview Nurse #3 who worked on 09/10/22 from 7:00 PM to 7:00 AM, but the attempts were unsuccessful. During an interview with Nurse #4 on 09/13/22 at 4:30 PM the Nurse explained that when the nurse inputs the order into the medication system it automatically informed the pharmacy of the order and the medication was sent in the next pharmacy delivery to the facility. The Nurse continued to explain that if they had a prescription, it could be faxed to the pharmacy and the medication would come in the next delivery run as well. The Nurse stated they could always call the pharmacy and the facility would deliver the medication stat if needed. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/13/22 at 5:00 PM during an interview with the Director of Nursing (DON) the DON stated that she had already been made aware of Resident #38's medication situation. The DON explained that it was unacceptable for the Resident to not receive the newly prescribed medication for three days. The DON stated Nurse #1 should have faxed the new medication order to the pharmacy and also made the follow up telephone call to the pharmacy to ensure the pharmacy had received the order. An interview was conducted with the previous Nurse Practitioner (NP) on 09/14/22 at 6:42 PM who stated she was familiar with Resident #38. The NP explained that she would have expected the prescription was successfully faxed and received by the pharmacy so that the medication could have been started on the next pharmacy delivery. The NP stated it was unacceptable for Resident #38 to not receive his medication all weekend.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 35789 Based on observation, record review, staff, and Consultant Pharmacist interviews the facility failed to remove expired medication and date open insulin pens from 1 of 3 medication carts (300 hall medication cart) and failed to remove loose unsecured pills from 2 of 3 medication carts (100 hall/200 hall cart and 300 hall cart) reviewed for medication storage. The findings included: 1a. An observation of the 300-hall medication cart was made on 09/12/22 at 11:16 AM along with Nurse #8 revealed the following: Glipizide (used to treat diabetes) 10 milligrams (mg) 16 tablets that expired on 07/31/22, Novolin 70/30 insulin pen that was opened on 07/29/22, Lantus insulin pen with no date of when it was opened, and Glargine insulin pen with no date of when it was opened. The observation also revealed the following loose unsecured pills that were found in the bottom of the medication drawers on the cart: 2 large oval white pills, 4 smaller oval white pills, 1 pink oval pill, 1 white capsule, 1 large round white pill, 2 small round white pills, 1 small oval blue pill, 1 peach oval pill, 3 beige round pills, 1 half white oblong pill, 1 square brown pill, and 1 oblong yellow pill. Nurse #8 was interviewed on 09/12/22 at 11:26 AM and stated she worked at the facility through an agency. She stated that she had gone through her medication cart this morning labeling eye drops and to ensure the medication cart was clean. Nurse #8 was unable to confirm when the Lantus or Glargine insulin pen were opened but stated she would contact the pharmacy for replacements Nurse #8 stated she would have to call the pharmacy and find out how long the Novolin 70/30 was good for after opening because she was not sure. Nurse #8 stated that since she did not know when the insulin pens were opened, she did not know when they expired. She added that all insulin pens and vials should be dated when opened. Nurse #8 stated that when she went through her medication cart this morning she did not check for expired medication and did not realize that the Glipizide was expired but stated she would discard that and the loose unsecured pills that were found on the medication cart. 1b. An observation of the 100/200 hall medication cart was made on 09/12/22 at 3:45 PM along with Nurse #5. The observation revealed the following: 7 round white pills, 3 oblong yellow pills, 2 square brown pills, 1 white oblong pill, 2 round blue pills, 2 small round pink pills, 2 peach round pills, and 3 oblong green pills that were loose and unsecured not in their original package in the medication drawers. Nurse #5 was interviewed on 09/12/22 at 3:51 PM and stated she had discarded the loose unsecured pills that were found in the medication drawers. She stated she could not identify the pills or who they belonged to, so she discarded them. Nurse #5 explained she was an agency nurse and had briefly gone through her medication cart this morning checking dates but did not notice the loose pills that had fallen out of their original package. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Consultant Pharmacist was interviewed on 09/12/22 at 3:12 PM. She stated that the Novolin 70/30 insulin pen was good for 42 days after opening and the Lantus and Glargine insulin pens were good for 28 days after opening and then should be discarded. The Pharmacist stated that she had recently visited the facility during her monthly visit and had audited 10% of the medication carts and checked for expired medication. She indicated that on her 08/31/22 visit she had some concerns that she had sent to the Director of Nursing (DON). Review of the Quality Improvement Consultant Pharmacist Summary dated 08/31/22 under the section labeled Drug Storage and Security read in part: 100/200 cart found expired medication and 6 insulin pens that were note dated. 300 hall cart: please date all pens (worked with nursing to date the insulins in the carts). The report was electronically signed by the Consultant Pharmacist. The DON was interviewed on 09/12/22 at 3:15 PM. The DON stated that each nurse should be going through the medication carts daily to ensure there were no expired medications and to ensure the insulins, eye drops, and over the counter medications were all dated when opened. The DON confirmed the Novolin 70/30 was good for 42 days and should have been discarded on 09/09/22 and the Lantus and Glargine should have been dated when opened and discarded 28 days later. The DON stated she had received the Consultant Pharmacist report but had not had time to go through the full report yet. She expected all expired medication and any loose unsecured pills to be immediately discarded.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35789 Based on observations and staff interview the facility failed to remove expired refrigerated food items and food items with signs of spoilage stored ready for use, failed to date opened containers of food stored in the reach-in cooler and failed to ensure 1 of 1 refrigerator was free from dust and black slimy substance. These practices had the potential to affect food served to residents. The findings included: An observation of the kitchen was made on [DATE] at 10:42 AM along with the Dietary Manager (DM). The observation revealed the following in the reach in cooler of the kitchen: one opened container of chicken base with no date of when it was opened and a bag of lettuce that was red/brown and appeared slimy. The observation also revealed in the refrigerator of the kitchen six ,d+[DATE] gallons of butter milk that expired on [DATE]. The refrigerator was also observed to have dust on the inside ceiling to the left of the door that came from the fan that was attached to the refrigerator. On the right side of the ceiling of the refrigerator was a black slimy substance. The DM was interviewed on [DATE] at 5:34 PM. She stated that the buttermilk was delivered on [DATE] early in the morning before any of the dietary staff arrived at the facility and she stated she had not gone behind the delivery man and checked the dates of the milk. She stated that the delivery person usually rotated all the milk products and generally she did not have any issues. The DM stated that everyone that goes into the cooler and refrigerator has a responsibility to check dates and discard food items that were expired, unlabeled or has signs of spoilage. She added that she had thrown the butter milk away along with the chicken base and lettuce. The DM further stated that she had weekly and a monthly cleaning schedule and each area or piece of equipment was assigned to a staff member. She stated that the ceiling of the refrigerator was not on the schedule, and she had been working the last 3 days and had not noticed the dust or black slimy substance on the ceiling. The DM stated she was immediately going to clean it and add it to her weekly cleaning schedule for completion by the dietary staff. The Administrator was interviewed on [DATE] at 3:45 PM and stated that he expected the kitchen to be kept clean and tidy and all expired food to be discarded.

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F 0867 Level of Harm - Actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35789 Based on observations, record review, resident, and staff interview the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the recertification survey completed on [DATE] and the complaint investigation completed on [DATE], [DATE], and [DATE]. This was for three repeat deficiencies in the area of respiratory care, supervision to prevent accidents, and prepare and serve food under sanitary conditions that were originally cited on [DATE] during a recertification survey and complaint survey for four repeat citation in the area of notification, supervision to prevent accidents, significant medication errors, serve food under sanitary conditions, and infection control that was cited on [DATE], [DATE], and/or [DATE] during a complaint investigation. The continued failure of the facility during three federal surveys showed a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Program. The finding included: This citation is cross referred to: F580: During the recertification of [DATE] the facility failed to notify the Physician of a medication unavailability for 1 of 1 resident (Resident #38) reviewed for pain. During the complaint investigation of [DATE] the facility failed to notify the medical provider of a delay in administering an antibiotic and steroid for 1 of 4 sampled residents. F689: During the recertification of [DATE] the facility failed to provide care in a safe manner for 1 of 4 residents reviewed for accidents. The resident rolled out of bed during care and sustained a laceration above his eye along with contusions to his head, skin tear to left elbow and a skin tear just above the left wrist (Resident #33). During the recertification of [DATE] the facility failed to determine the root cause analysis of a Resident's fall with no injury, in order to implement effective interventions to prevent further falls for 1 of 5 residents reviewed for accidents. During the complaint investigation of [DATE] the facility failed to provide supervision to prevent accidents by leaving a resident unassisted on the toilet while summoning assistance which resulted in a resident being lowered to the floor. Once the resident was lowered to the floor the facility failed to assess the resident and subsequently failed to notify the medical provider. The resident sustained an acute fracture of the tibia and fibula. This affected 1 of 3 residents (Resident #1) investigated for providing care according to professional standards. F695: During the recertification survey of [DATE] the facility failed to keep air filters on oxygen concentrators clean and free from dust buildup for 1 of 3 residents reviewed for respiratory care (Resident #24). (continued on next page)

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F 0867 Level of Harm - Actual harm Residents Affected - Few	During the recertification survey of [DATE] the facility failed to administer oxygen as ordered and failed to replace oxygen cannula that had been placed on the floor for 2 of 3 residents reviewed for respiratory management. F760: During the recertification of [DATE] the facility failed to prevent a signification medication error when they failed to obtain and administer a steroid medication as ordered by the Physician for 1 of 2 residents reviewed for pain (Resident #38). During the complaint investigation of [DATE] the facility failed to administer an antibiotic and steroid per the Physician's order for 1 of 4 residents sampled. F812: During the recertification survey of [DATE] the facility failed to remove expired refrigerated food items and food items with signs of spoilage stored ready for use, failed to date opened containers of food stored in the reach-in cooler and failed to ensure 1 of 1 refrigerator was free from dust and black slimy. These practices had the potential to affect food served to residents. During the complaint survey of [DATE] the facility failed to follow their recipe for pureed egg salad and failed to serve pureed egg salad, a potentially hazardous food at 41 degree or below per the recipe on the lunch tray line for 1 of 1 observed meal. This had the potential to affect 2 of 12 residents on the 100 hall. The facility also failed to remove expired food items and unlabeled food items from 1 of 1 refrigerator, 1 of 1 freezer, 1 of 1 dry storage areas, and 1 of 2 (200 hall) nourishments rooms reviewed. During the recertification survey of [DATE] the facility failed to label, and date opened food items in one of two kitchen refrigerators and one of one nourishment room refrigerators and failed to remove expired items from one of one nourishment room refrigerators. F880: During the recertification survey of [DATE] the facility failed follow the Center for Disease Control and Prevention (CDC) guidelines and facility policy when they did not identify Covid 19 positive residents and failed to place them on transmission-based precautions, therefore the staff (Nurse Aide (NA) #3, NA #4, and Housekeeper #1) failed to don/doff personal protective equipment (PPE) when entering and exiting a Covid 19 positive room and before interacting with other residents (Resident#35, Resident #41, and Resident #44) this affected 3 of 24 residents on 1 of 4 units (memory care unit.) The facility failed to have personal protective equipment available for the staff to use when caring for Covid 19 positive residents that resided on the memory care unit. The facility was in outbreak status that started on [DATE] and affected 10 of 24 residents on the memory care unit. There were 5 residents that had not had Covid 19 in the last 90 days and of those 5 residents 1 was unvaccinated against Covid 19. The facility further failed to identify and prevent the spread of scabies (a very contagious skin condition caused by a tiny burrowing mite). This affected 2 of 4 units in the facility (100 and 200 units). During the complaint investigation of [DATE] the facility failed to follow the facility hand washing policy when 1 of 3 staff members (Nurse Aide #2) failed to wash her hands and change her gloves between contact between 2 residents (Resident #2 and Resident #3) on 1 of 4 halls (300 hall) and also failed to follow Center for Disease Control and Prevention (CDC) guidelines regarding appropriate Personal Protective Equipment (PPE) for counties of high transmission rate when 1 of 1 Hospice Staff failed to wear eye protection when providing care to 1 of 1 resident (Resident #1). The failure occurred during a COVID-19 pandemic. (continued on next page)

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F 0867 Level of Harm - Actual harm Residents Affected - Few	The Administrator was interviewed on [DATE] at 6:15 PM. The Administrator stated he has not had the opportunity to have a QA meeting since he came to the facility a few weeks ago. He stated the QA members were made up of the Administrator, the Director of Nursing, Dietary Manager, Business office manager, Maintenance Director, Social Worker, Activities Director, Housekeeping director, Nurse Supervisor and the Medical Director was always invited. The Administrator stated that he currently had 5 areas that the facility was currently working on improving and obviously we will look at the things identified during the survey. He stated he was made aware of the issues as they were identified during the survey but did not realize how significant they were. The Administrator stated he had to have consistent staff especially with infection control to make progress and maintain that progress. He added he would be holding staff members accountable and especially the department managers and he believed through consistency and accountability the facility can achieve substantial compliance.

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35789 Based on observations, record review, staff, Nurse Practitioner, and Medical Director interviews the facility failed to follow the Center for Disease Control and Prevention (CDC) guidelines and facility policy when they did not identify Covid 19 positive residents and failed to place them on transmission-based precautions, therefore the staff (Nurse Aide (NA) #3, NA #4, and Housekeeper #1) failed to don/doff personal protective equipment (PPE) when entering and exiting a Covid 19 positive room and before interacting with other residents (Resident#35, Resident #41, and Resident #44) this affected 3 of 24 residents on 1 of 4 units (memory care unit.) The facility failed to have personal protective equipment available for the staff to use when caring for Covid 19 positive residents that resided on the memory care unit. The facility was in outbreak status that started on 08/26/22 and affected 10 of 24 residents on the memory care unit. There were 5 residents that had not had Covid 19 in the last 90 days and of those 5 residents 1 was unvaccinated against Covid 19. The facility further failed to identify and prevent the spread of scabies (a very contagious skin condition caused by a tiny burrowing mite). This affected 3 of 4 residents (Resident #21, Resident #17, and Resident #61 that resided on 2 of 4 units in the facility (100 and 300 units). Immediate jeopardy began on 09/11/22 when the facility direct care staff and housekeeping staff were unable to identify the Covid 19 positive residents or rooms on the memory care unit. The staff were observed caring for Covid 19 positive residents without personal protective equipment and then caring for and/or interacting with Covid 19 negative residents. The immediate jeopardy was removed on 09/13/22 when the facility provided and implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity Level G (actual harm that is not immediate jeopardy) to implement a plan of correction for the second example. The findings included: Review of a facility document titled, Hand Hygiene dated 12/01/06 read in part, wash hand with soap and water in the following situations: when visibly soiled or contaminated, before any direct contact with residents, before putting on gloves, after contact with residents ' intact skin, after contact with inanimate objects in the immediate vicinity of the resident and after removing gloves. Review of a facility document titled, Suspected Covid 19 Facility Checklist revised on 07/30/21 read; for all suspected or confirmed patients: close door to affected patients' room and wear appropriate PPE when entering the room(s) of affected patients (gown, gloves, full face shield, N95 respirator). Review of the Center for Disease Control and Prevention (CDC) guidelines dated 02/02/22 read in part, Manage Residents with Suspected or confirmed SARS-CoV-2 (Covid 19) infection: Healthcare personnel caring for residents with suspected or confirmed SARS-CoV-2 infection should use full personal protective equipment (gowns, gloves, eye protection, and a NIOSH-approved N95 or equivalent or higher-level respirator). 1a. Upon entrance to the facility on [DATE] at 10:32 AM the Nurse Supervisor stated that the facility had 5 of 24 residents that were Covid positive, and all resided on the 400 hall that was the facility's memory care unit. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An observation of the door to the memory care unit was made on 09/11/22 at 10:44 AM, the door contained a sign that read: Patient Specific: Contact Plus Airborne Precautions: STOP: Perform hand hygiene before and after patient contact with environment and after removal of PPE, Wear a N95 respirator, Gown, Face shield and gloves upon entering the room. Change gown after each patient contact, keep room door closed. There was no PPE available at the entrance to the unit. Nurse #6 was interviewed on 09/11/22 at 11:15 AM and confirmed that he was working on the memory care unit of the facility, and he was unable to confirm who the Covid 19 positive residents were but stated he had a list at the station. After Nurse #6 retrieved his list, he was able to report that the follow rooms were Covid positive rooms: room [ROOM NUMBER] A and B, room [ROOM NUMBER] B, room [ROOM NUMBER] A, room [ROOM NUMBER] A, room [ROOM NUMBER] B, and room [ROOM NUMBER] B. Observation of the memory care unit was made on 09/11/22 at 11:45 AM and revealed that room [ROOM NUMBER] room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], and room [ROOM NUMBER] contained no sign on the door indicating that either resident in the room were Covid positive. The observation further revealed that there were 2 PPE containers sitting on the hallway of the unit. One at the far end of the hallway and one near the upper end of the hallway. Neither PPE cart contained any gowns for the staff to wear. Each PPE cart contained a box of gloves and a few N95 mask but no other PPE. The residents in room [ROOM NUMBER], 405, 406, 408, and 409 were all in their rooms in their bed. The resident in room [ROOM NUMBER] which had a transmission-based precaution sign on their door was ambulating and wandering in/out of other resident rooms on the unit. A follow up interview was conducted with Nurse #6 on 09/11/22 at 3:03 PM who confirmed he only worked the memory care unit when he worked at the facility through an agency and had worked on 09/10/22 and 09/11/22 twelve-hour shifts. Nurse #6 stated that they kept a list of the Covid positive residents and room numbers at the nurse's station and he would always verify the information with the off going nurse in report. He stated that the Nurse Aides (NAs) would get report from the off going NAs about which residents who were Covid positive and if they did not get that information, they could always ask the nurse on the unit. Nurse #6 stated I treat the whole hall as a Covid unit. He stated we are supposed to have gowns, gloves masks and goggles on the unit but he could not say why they did not have personal protective equipment on both 09/10/22 and 09/11/22. Nurse #6 stated they were not supposed to leave the hall to get supplies and was not aware if the facility had supplies in other areas of the facility or not. He indicated that he wore his N95 mask for the duration of his 12-hour shift and was not aware of what the protocol was for changing his N95 mask. Nurse #6 confirmed that during the weekend of 09/10/22 and 09/11/22 he had not called the other side of the facility or the Director of Nursing (DON) to obtain the personal protective equipment and stated, in the past they have brought it to us. He further added that when a resident tested positive for Covid the PPE container did not always get put out for use by the staff on the unit. 1b. Resident #13 admitted to the facility on [DATE] and resided in room [ROOM NUMBER] B and tested positive for Covid 19 on 09/05/22. Resident #24 was readmitted to the facility on [DATE] and resided in room [ROOM NUMBER] A and tested positive for Covid 19 on 09/08/22. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	NA #3 and NA #4 were observed to enter room [ROOM NUMBER] (both Covid positive) on 09/11/22 at 11:45 AM wearing a N95 mask and eye protection. They were observed to interact with both residents and their environment. They adjusted covers on bed, moved bedside tables and touched Resident #13's hand. NA #3 and NA #4 exited the room and neither changed their N95 mask or cleaned or disinfected their eye protection and did not perform hand hygiene. They exited into the hallway and entered the common area on the unit where other residents were located. NA #3 and NA #4 were interviewed on 09/11/22 at 11:48 AM. Neither NA #3 nor NA #4 could verbalize who the Covid positive residents were on the unit. They both confirmed that this was their weekend to work and during report no one gave them the names or room numbers of the Covid positive residents. Both NAs stated that sometimes they had a Covid positive and Covid negative in the same room and it was so confusing on what they should do with their PPE. NA #3 stated that if she was aware that a resident was Covid positive then she would put on a gown before entering the room but stated we don't have any right now and we did not have any yesterday either and of course we already have on goggles and N95 mask. NA #3 stated that when they came out of a Covid positive room they would remove their gown and gloves but did not change their N95 mask or clean/disinfect their goggles. NA #4 confirmed that they wore their N95 mask for the duration of their 12-hour shift on the memory care unit. Both NAs stated that none of the residents had any symptoms of Covid 19 and added we treat everyone like their positive. NA #3 stated that they had not received any education since their Nurse Educator that was here temporarily left a few weeks ago but added that they used to get education on Covid and PPE pretty often. A subsequent observation of NA #3 was made on 09/11/22 at 3:14 PM. There was a sign on the door of room [ROOM NUMBER] that read; Contact Plus Airborne Precautions: STOP Perform hand hygiene before and after patient contact with environment and after removal of PPE, Wear a N95 respirator, Gown, Face shield and gloves upon entering the room. Change gown after each patient contact, keep room door closed. NA #3 entered room [ROOM NUMBER] (both resident Covid positive) wearing a N95 mask and goggles. She reapplied Resident #24 ' s oxygen cannula in his nose and moved his bedside table back within his reach. She exited the room without performing hand hygiene or changing her N95 mask and she did not clean/disinfect her eye protection. Once in the hallway NA #3 was observed to approach two wandering residents (Resident #35 (who was currently Covid negative but had Covid 07/19/22) and Resident #41 (who was currently Covid negative but had Covid 08/03/22) and grab their hand and walk them down the hallway to the common area again without performing hand hygiene. NA #3 was interviewed on 09/11/22 at 3:16 PM. NA #3 stated that if she was aware that a resident was Covid positive then she would put on a gown before entering the room but stated we don't have any right now and we did not have any yesterday either and of course I already have on goggles and N95 mask. NA #3 stated that when she came out of a Covid positive room she would remove her gown and gloves but did not change her N95 mask or clean/disinfect her goggles. She stated she had not noticed the sign on the door when she entered room [ROOM NUMBER] but also there was no gowns for her to apply anyway when she entered the room. NA #3 also stated that she forgot about using hand sanitizer because when she walked out of room [ROOM NUMBER] there were 2 residents in the hallway that she needed to redirect. 1c. Resident #36 was admitted to the facility on [DATE] and resided in room [ROOM NUMBER] B and tested positive for Covid 19 on 09/06/22. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An observation of Resident #36 was made on 09/11/22 at 11:59 AM. Resident #36 was observed wandering on the memory care unit. She was observed to enter room [ROOM NUMBER] (Resident#44 who resided in 408 B was Covid Negative) and shut the door behind her. Nurse Aide (NA) #3 was notified that Resident #36 had gone into room [ROOM NUMBER] and shut the door on 09/11/22 at 12:03 PM. NA #3 replied she is hiding in that room she will be ok and continued up with the hallway without redirecting Resident #36 out of the room. An observation of Housekeeper #1 was made on 09/11/22 at 3:17 PM. Housekeeper #1 was observed in the hallway wearing a N95 mask and a face shield he was observed to enter Resident #36's room that had a sign on the door that read: Contact Plus Airborne Precautions: STOP Perform hand hygiene before and after patient contact with environment and after removal of PPE, Wear a N95 respirator, Gown, Face shield and gloves upon entering the room. Change gown after each patient contact, keep room door closed. Housekeeper #1 was observed to enter the room and place a trash bag in the trash can and then enter the bathroom and exit out of the adjoining room which was room [ROOM NUMBER] (Covid negative) room. He returned to the housekeeping cart in the hallway and proceed to empty the trash and clean the trash can. Housekeeper #1 did not change his N95 mask, clean/disinfect his eye protection or perform hand hygiene in between a Covid positive room and a Covid negative room. Housekeeper #1 was interviewed on 09/11/22 at 4:36 PM. He stated that he did not see the sign on the door of room [ROOM NUMBER], so he did not apply his gown or gloves and did not change his N95 mask when he exited the room. Housekeeper #1 stated that generally if he was entering a Covid positive room he would follow the instructions on the door as to what personal protective equipment he needed to apply but because he had not seen the sign posted on the door, he had not done that earlier in the day. An observation of NA #4 was made on 09/12/22 at 8:32 PM. NA #4 was observed to enter Resident #36's room wearing gown, gloves, N95 mask and eye protection and provided morning care to Resident #36 and assisted her with meal set up. Prior to exiting Resident #36's room NA #4 removed her gown and gloves and bagged them in a trash bag and exited the room she did not clean/disinfect her eye protection and did not change her N95 mask. NA #4 was interviewed on 09/12/22 at 8:33 AM and confirmed that she had removed her gown and gloves but had not changed her N95 mask or clean/disinfected her goggles and she should have. NA #4 could not provide a reason why she did not change her N95 mask or clean/disinfect her goggles. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The former Nurse Practice Educator was interviewed via phone on 09/13/22 at 2:52 PM via phone. The former Nurse Practice Educator stated that she had worked at the facility through an agency and a couple of weeks into her contract the Director of Nursing (DON) informed her that she would also be responsible for maintaining the infection control program at the facility. She stated she was responsible for ensuring appropriate signage was on the door if we had Covid 19 positive resident in the facility, ensuring PPE was available, ensure staff were wearing the PPE correctly, provide education on donning/doffing PPE, hand washing, Covid testing, keeping line listing of infections and tracking resident quarantine days. The Nurse Practice Educator stated the biggest issue she had was the staff was not compliant at all no one wanted to apply the PPE correctly. The Nurse Practice Educator explained that she was on vacation when the memory care unit had its first initial outbreak on 08/05/22, she stated when she returned to work on Monday 08/08/22 and found out that they had 7 residents that tested positive on 08/05/22 and nothing had been done. She stated that on 08/08/22 in the afternoon the former Administrator had asked her to round with him to ensure that all the pieces had been implemented for the outbreak on the memory care unit, she stated when they rounded, she discovered that there was no signage posted on door, no PPE on the unit, and staff were not wearing the appropriate PPE to be caring for Covid positive residents. The former Nurse Practice Educator stated that she immediately began implementing the appropriate measures, she placed signs on the doors, obtained PPE carts and filled them and put them outside of the resident rooms and she educated the staff on appropriate PPE use. She stated that when she would say to the staff in the facility pull your mask up, they would respond we have already had covid and would not follow directions. She stated that she made the DON aware of the issues and questioned her why the measures were not implemented when the residents tested positive but received no answer. When a resident tested positive for Covid the staff were taught and expected to wear full PPE including N95 mask, eye protection, gown, and gloves. They were also taught and expected to remove the PPE when they exited the Covid positive room perform hand hygiene and reapply a new N95 mask and new face shield. Again, compliance was always the biggest issue with infection control in the facility. The Nurse Practice Educator stated she had specific concerns with NA #3 and NA #4 that she had spoken to them several times and educated them several times during the first outbreak on the memory care unit and they just would not wear the PPE correctly. She added the DON was informed numerous times of my concerns with the staff noncompliance and the only response she would get if any at all was that we have to cover the building. The former Administrator was interviewed via phone on 09/13/22 at 5:14 PM and confirmed that his last day at the facility was 08/26/22. He stated that at the time the Nurse Practice Educator was handling infection control and reporting to the health department as needed. He stated that when he left the faciity on [DATE] there was no positive cases of Covid 19. When asked if he had any issue with infection control the former Administrator replied, we had error of opportunity and I constantly harped on staff to put goggles on and pull your mask up. He further stated he had the department managers responsible for stocking PPE carts each day and the biggest issue was the off-hour times like early morning, late evening, and weekends when management staff was not always present. The former Administrator stated that they did a lot of coaching in the moment to ensure mask were properly worn but to his knowledge he had no egregious issues with compliance. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The Nurse Supervisor was interviewed on 09/14/22 at 10:16 AM and confirmed that she had seen staff not being compliant with PPE all the time. She stated she believed staff noncompliance with PPE contributed to the facility's Covid outbreaks. The Nurse Supervisor stated that when the residents that resided on the memory care unit test positive everyone should have been isolated but the staff noncompliance contributed to the continued outbreak. She stated night shift on the memory care unit was the worst for compliance with PPE but added NA #3 and NA #4 were also very non-compliant more so than the other staff. The Nurse Supervisor stated she would address her immediate concerns with the staff member at the time but could not say if the DON was aware of the staff noncompliance or not as she just assumed the Nurse Supervisor role and was not sure what previous conversations had been had. The Nurse Practitioner (NP) was interviewed via phone on 09/14/22 at 6:29 PM who stated she worked at the facility from January 2022 to August 2022 and treated the residents as they tested positive for Covid. She stated if staff were not wearing PPE as they were supposed to then it would have caught her attention. She stated she had no infection control concerns that she could recall. The DON was interviewed on 09/11/22 at 12:54 PM who confirmed she was the acting infection preventionist because the former Nurse Practice Educator who was responsible for infection control left 2 weeks ago. The DON stated she had been at the facility since January 2022 and the facility had been in outbreak status the entire time except for one week. The DON explained that the outbreak on the 400 hall or memory care unit started in August 2022 and currently all but 5 of the residents have had Covid in the last 90 days. The DON stated that of the 5 residents who had not had Covid in the last 90 days two were fully vaccinated and boosted/ up to date, one was only partially vaccinated, one was vaccinated without booster and one resident vaccination status was unknown. The DON stated that she worked Friday 09/09/22 until 11:00 PM and when she left the facility the memory care unit had a good supply of PPE, in addition there was more PPE on the other side of the building and even more in storage building outback that was not locked so it was accessible by all staff. She confirmed that she had not received any calls from the facility on 09/10/22 or 09/11/22 stating they needed or did not have PPE. The DON stated that each resident room that had a Covid 19 positive resident in it should have a sign on the door indicating Contact/Airborne precautions and tell staff to don eye protection, gloves, gown, and N95 mask before entering the room. There should be PPE carts outside of each of the resident rooms that were fully stocked with PPE for staff to use. She continued to say that education on Covid 19 and PPE use had been a constant revolving door and indicated the facility had done full PPE and hand hygiene competencies twice recently but could not recall the exact dates. Periodic emails were sent out to staff updating them on any changes with guidance and they also continued to have staff meetings to keep staff aware of the Covid status and changes. The DON stated that the local health department had made a visit less than a month ago and had no recommendations related to Covid 19. The Administrator was interviewed on 09/14/22 at 3:45 PM and stated that he expected the staff to follow the CDC guidance on infection control and for all staff to be compliant with PPE use to prevent the spread of infection. The Medical Director (MD) was interviewed on 09/14/22 at 4:10 PM and confirmed that he had been the MD at the facility since the summer of 2022. He stated that when he came to the facility, they were in the middle of a Covid outbreak. He also confirmed that staff made him aware of the recent outbreak on the memory care unit. The MD stated that he expected the staff to wear PPE appropriately, they should be performing frequent hand hygiene, and they should certainly be aware of who the Covid positive residents were all in attempt to prevent the spread of the Covid 19 within the facility. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The DON was notified of the immediate jeopardy on 09/11/22 at 8:02 PM via phone. The facility provided the following immediate jeopardy removal plan: Identify those residents who have suffered, or are likely to suffer a serious adverse outcome as a result of the noncompliance: Facility failed to follow transmission-based precautions and use of personal protective equipment (PPE) per CDC Guidance on the Memory Support Unit on 9/11/22. All residents on the Memory Support Unit have potential to be affected. As of 9/11/22 there were 24 residents on the Memory Support Unit, with 7 of them being Covid Positive, 12 Covid Recovered in the last 90 days, leaving 5 residents at risk for exposure to Covid due to this deficient practice. Testing was completed in the morning of 9/12/22 by 8:30 a.m., with no new positive residents. The 5 residents at risk have the following vaccination status: two fully vaccinated and boosted/ up to date, one with only initial dose of a 2 dose vaccination (partially vaccinated), refused the second dose/ partially vaccinated, one vaccinated without booster- booster declined/ fully vaccinated, and one status unknown. On 9/11/22 at approximately 7 p.m. the Director of Nursing responded to the Memory Support Unit and provided education for NA # 1 and # 2. The Director of Nursing assigned the RN Supervisor to the unit to monitor for compliance with immediate action taken for any discrepancies noted. Director of Nursing stayed at center and educated night shift staff on the Memory Support/Covid Positive unit on 9/11/22. Director of Nursing restocked the PPE supplies on the Memory Support Unit/Covid Positive Unit, on day shift on 9/11/22 and again on evening shift on 9/11/22. Specify action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when action will be complete: Director of Nursing began education for all staff in all departments on 9/11/22 and continues on 9/12/22, regarding CDC Guidance for use of PPE/ Transmission Based precautions during an outbreak and hand hygiene. Education also included the location of PPE Supplies in the event that they are needed during off shifts/weekends to restock units, located in the Biohazard Room and in the storage building in back parking lot, this is unlocked and available to all staff. Education included that staff should monitor each other, peer to peer for PPE compliance and report noncompliance to management. Education included disinfecting of eye protection and changing of N95s between Covid positive and Covid negative residents and the use of gloves and gowns (don and doff gloves and gowns on entry to a room with a resident on Transmission Based Precautions and to change gloves and gowns between roommates). Education included following the precaution signage on resident rooms and the location of a list of residents on precautions maintained at the nurse's station. Signage will designate if precautions are indicated for Bed A, Bed B or both, this was initiated on 9/12/22. This education included Full Time, Part Time, PRN (as needed) and Agency Staff. Across all departments. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Education will continue for all new hires and new agency staff, and no staff shall work until education completed. The Director of Nursing is responsible for tracking who still needs education and providing the education. Part-time and prn staff being educated via phone, and then in person upon next scheduled shift. On 9/11/22 signage was replaced on all resident's rooms who were Covid positive and required transmission-based precautions, and a list updated and kept at nurse's station in the event that the cognitively impaired residents remove the signage by the Director of Nursing. Nursing Management (Director of Nursing and Nursing Supervisor) responsible for monitoring that signage is in place and replaced as needed. The Nursing Supervisor is responsible for keeping the list updated daily as of 9/12/22. Nursing Supervisor and Director of Nursing educated by the Regional Nurse regarding this responsibility to include keeping the list and signage up to date for all residents that require Transmission Based Precautions and those that are coming off precautions on 9/12/22. Current signage follows CDC Guidance. Immediate plan of correction initiated on 9/12/22 which included management assigned to complete surveillance on all shifts and weekends on appropriate PPE use, PPE supplies and Hand hygiene. This surveillance will be documented on the Covid- 19 Walking Infection Control Rounding Tool. The Management Team consisting of the Administrator, Director of Nursing, Nursing Supervisor, Social Service Director, Activities Director, Central Supply, Business Office Manager, and Manager on Duty, were educated by the Regional Nurse on 9/12/22 regarding how to complete the Covid 19 Walking Infection Control Rounds and ensuring that there is an adequate PPE supplies stocked on the units. PPE is routinely stocked during the week by the Central Supply Clerk, Weekends will be covered by Nursing Supervisor and/or the Manager on Duty. The surveillance for Infection Control Rounds and PPE supplies will be monitored by the Administrator through daily review of the Covid 19 Walking Infection Control Rounds tool, which monitors the following: 1) rooms on transmission based precautions are clearly marked with signage 2) these rooms have the doors closed as residents will allow 3) staff perform hand hygiene before and after resident care and/or contact with resident/resident's environment 4) PPE is readily available 5) PPE is donned per CDC guidance- gloves, gowns, N95s and eye protection. 6) PPE is removed and discarded per CDC guidance. 7) staff follow procedures for cleaning/disinfecting eye protection 8) staff change gloves and perform hand hygiene after each patient. Management team (as outlined above and Manager on duty) will be assigned Covid-19 Walking Infection Control Rounds by the Administrator on a schedule that will cover both shifts 7 days per week. Administrator held an ADHOC QAPI Meeting to address this plan as well as the facility's current policy for transmission-based precautions during outbreak was reviewed and current with CDC guidelines on 9/12/22. Alleged date Immediate Jeopardy was removed, 9/13/22. The Administrator is responsible for the implementation of this plan. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. Building B. Wing	09/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lotus Village Center for Nursing & Rehabilitation	179 Combs Street Sparta, NC 28675

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A credible allegation of infection control was conducted in the facility on 09/14/22. Observations of the memory care unit on 09/14/22 revealed that all Covid positive rooms had a sign on the door indicating which resident was positive. Each Covid 19 positive resident room was observed to have a PPE cart outside of the room that was fully stocked with gowns, gloves, N95, and face shields. Each staff member was observed to have disinfecting wipes available to clean/disinfect their eye protection. The Nurse Supervisor was observed on the unit monitoring the infection control practices of the staff on the unit. Further observations revealed supplies of additional PPE to be located across from the main nurse ' s station, in the facility break room, and in a unlocked storage container out back of the facility. Interviews were conducted with staff members that worked in administration, nursing department, dietary department, maintenance department revealed that they had all received recent education on Covid 19, and appropriate PPE use along with hand hygiene. The managers at the facility verbalized understanding of their walking infection control rounds that they were to complete, and the supporting documentation required on the Covid 19 Walking Infection Control Round audit form. The facility's IJ removal date of 09/13/22 was validated. 45359 2. Review of the facility policy and procedure for scabies with an effective date of 9/1/2004 and review on 11/15/2021 revealed: Definition: Crusted (Norwegian) Scabies- single or multiple cases: an infestation characterized by thick crusts of skin that contain large numbers of scabies mites and eggs. It is a severe form of scabies. 1.Identify signs and symptoms of scabies: 1.1: intense itching, especially at night, 1.2: maculopapular rash, 1.3: tiny, irregular reddish lines (burrows), 2.1 Document daily patient skin checks for 8 weeks, 2.2 Maintain a high index of suspicion that scabies may be the cause of undiagnosed skin rash; suspected cases should be evaluated and confirmed by obtaining skin scrapings. 2.5 Maintain accurate line listings with patient name, age, sex, room number, roommate name, skin scraping status and result and name of all staff who provided hands on care to the patient before implementation of infection control measures. 2.10 Follow contact precautions until 24 hours after treatment. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2.13 Ensure bedding and clothing used by a person with scabies is collected and transported in a plastic bag and emptied directly into washer to avoid contaminating other surfaces and items. Machine wash and dry all items using the hot water and high heat cycles (temperature in excess of 50 degrees Celsius or 122 degrees Fahrenheit for 10 minutes will kill mites and eggs). Ensure laundry personnel use protective garments and gloves when handling contaminated items. 2.15 Store items that cannot be washed (shoes, slippers, pillows, stuffed animals, etc.,) in a sealed plastic bag for at least 72 hours. a. Resident #21 was admitted to the facility on [DATE]. Review of the admission Minimum Data Set (MDS) dated [DATE] revealed Resident #21 was cognitively intact and required extensive to total assistance with activities of daily living (ADLs). Review of Resident #21's care plan initiated on 7/8/2022 revealed a care plan in place for rash on admission to upper, inner and posterior thighs, bilateral buttocks, abdominal folds and bilateral groin with interventions of redirect from scratching, administer as needed anti-itch medication initiated 8/18/2022 and was treated for scabies initiated 7/26/2022. Review of physician's orders for July 2022 revealed an order on 7/20/2022 of apply Permethrin Cream 5% (medication used to treat scabies, a condition caused by tiny insects called mites that infest and irritate the skin) apply cream to entire body topically one time for scabies to include scalp and skin scrapping and send samples to lab one time only for screening for scabies. Both orders documented as completed by Nurse Supervisor on the Medication Administration Record. Review of Resident #21's skin che