STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345133	A. Building B. Wing	02/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridge Valley Center for Nursing and Rehabilitation	1000 College Street Wilkesboro, NC 28697

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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 0550 Level of Harm - Actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43643 Based on record reviews, observations and resident and staff interviews, the facility failed to treat residents in a dignified manner when staff did not provide scheduled bed baths requested. The resident expressed feelings of being dirty, unhappy, itchy, and unclean. This affected 2 of 3 residents reviewed for dignity and respect (Resident #7 and Resident #6). The findings included: 1.Resident #7 was admitted to the facility on [DATE] with diagnoses of hypertension and muscle weakness. A review of the admission Minimum Data Set (MDS) dated [DATE] indicated Resident #7 was cognitively intact. The MDS revealed Resident #7 was total dependent and required two staff assist for bathing. The MDS also indicated it was very important to for Resident #6 to choose between a tub bath, shower, or bed bath. An interview and observation with Resident #7 on 2/14/23 at 10:15 AM revealed she had not received consistent showers as scheduled since admission. Resident #7 further revealed she preferred bed baths and had to ask nursing staff on weekends to receive one. Resident #7 stated she felt unclean, and her hair felt dirty and had expressed this to staff multiple times. Observation revealed Resident #7 to have greasy and tangled hair and have facial expressions of being unhappy. An interview with Nurse Aide (NA) #1 on 02/15/23 at 2:05 PM revealed she worked on the shower team for the facility but was often pulled to the floor to assist other NAs due to short staffing. NA #1 further revealed Resident #7 had missed preferred bath baths multiple days and had complained of feeling nasty. NA #1 stated multiple residents had complained showers and baths were not being given as scheduled as preferred. An interview with NA #5 on 02/15/23 at 2:15 PM revealed assisted NA #1 with showers and baths and Resident #7 had not refused. NA #5 indicated the facility sometimes did not have enough NAs so staff assisting with showers would get pulled to the floor. NA #5 stated Resident #7 had expressed she had felt dirty at time due to not receiving a scheduled bed bath. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0550 Level of Harm - Actual harm Residents Affected - Few	An interview with Unit Manager (UM) #1 on 02/15/23 at 12:05 PM revealed she did not recall Resident #7 had refused preferred bed baths before. UM #1 further revealed NA's completing showers and baths had been pulled to the floor to assist other NAs due to staff who had called out. UM #1 indicated she was not aware #7 had missed multiple bed baths as scheduled and expressed feelings of being unclean. An interview with the Director of Nursing (DON) on 02/15/23 at 12:30 PM revealed Resident #7 preferred a bad bath and was not aware that she had missed several scheduled days and complained of feeling dirty. The DON further revealed she expected for Resident #7 and other residents to receive their shower or bath on scheduled days and to feel clean and comfortable. 2. Resident #6 was admitted to the facility on [DATE] with diagnoses of hypertension, and arthritis. A review of the admission Minimum Data Set (MDS) dated [DATE] indicated Resident #6 was cognitively intact. The MDS further revealed Resident #6 was total dependent and required two staff assist for bathing. The MDS also indicated it was very important to for Resident #6 to choose between a tub bath, shower, or bed bath. An interview and observation with resident #6 on 2/14/23 at 1:00 PM revealed he had not received consistent showers as scheduled since admission. Resident #6 further revealed he preferred bed baths and had told nursing staff he had not received preferred bed baths. Resident #6 stated he felt dirty and itchy and wanted his bed baths as scheduled and had expressed this to nursing staff. Observation revealed Resident #6 to have an odor. An interview with NA #1 on 02/15/23 at 2:05 PM revealed she worked on the shower team consistently for the facility but was often pulled to the floor to assist other NAs due to short staffing. NA #1 further revealed Resident #6 had missed preferred bath baths multiple days and had complained of feeling dirty. NA #1 stated multiple residents had complained showers and baths were not being given as scheduled as preferred. An interview with NA #5 on 02/15/23 at 2:15 PM revealed assisted NA #1 with showers and baths and Resident #6 had not refused. NA #6 indicated the facility sometimes did not have enough NAs so staff assisting with showers would get pulled to the floor. NA #5 stated Resident #6 and other residents had complained they had not received showers or baths as scheduled. An interview with Unit Manager (UM) #1 on 02/15/23 at 12:05 PM revealed she did not recall Resident #6 had refused preferred bed baths and had expressed he had felt dirty. UM #1 further revealed NAs completing showers and baths had been pulled to the floor to assist other NA's due to staff who had called out. UM #1 indicated she was not aware #6 had missed multiple bed baths as scheduled. An interview with the Director of Nursing (DON) on 02/15/23 at 12:30 PM revealed Resident #6 preferred a bad bath and was not aware that he had missed several scheduled days and complained of feeling dirty. The DON further revealed she expected for Resident #6 and other residents to receive their shower or bath on scheduled days and to feel clean and comfortable.

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety 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** 35789 Based on interview, record review, staff, Medical Director, Telemedicine Physician, Regional Medical Director, and Infectious Disease Provider the facility failed to notify the Infectious Disease Provider that was managing Resident #1's intravenous (IV) antibiotic which was being used to treat a right subdural empyema (collection of pus between the layers of the brain) and Cerebritis (inflammation of cerebrum of the brain) that Resident #1's peripherally inserted central catheter (PICC) (an IV used to administer medications) had become dislodged and his antibiotics were not administered as ordered for 1 of 1 resident reviewed for significant medication errors. There was the high likelihood for bacterial regrowth, resistance to antibiotic, sepsis, or return to hospital due to the missed medications. Immediate jeopardy began on 12/22/22 when the facility failed to notify the Infectious Disease Provider Resident #1's PICC line became dislodged, and the IV antibiotics were not being administered as ordered. Immediate jeopardy was removed on 02/17/23 when the facility provided an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems are in place and the completion of employee education. The findings included: Resident #1 was admitted to the facility on [DATE] with diagnoses that included: brain metastasis (cancer that has spread to the brain), chronic subdural hematoma, and sepsis. The physician order dated 12/18/22 read, Oxacillin (antibiotic) 10 grams (gm) reconstituted. Use 12 gm IV one time a day for encephalitis/sepsis for 27 days. Infuse 12 gm over a 24-hour period. The Medication Administration Record (MAR) dated 12/2022 revealed that Nurse #3 was responsible for administering Resident #1's Oxacillin on 12/18/22, 12/19/22, 12/21/22, and 12/23/22. Nurse #2 was responsible for administering Resident #1's Oxacillin on 12/20/22, 12/22/22, and 12/24/22. Nurse #4 was responsible for administering Resident #1's Oxacillin on 12/25/22. A nurse's note dated 12/22/23 at 7:34 AM written by Nurse #1 read, made aware that resident's PICC line was out and at the foot of the bed. Writer noted PICC line of 45 centimeters on the floor and asked resident what happened. Per resident he got caught up turning in bed and must have pulled it out. On coming nurse made aware for replacement. Nurse #1 was interviewed via phone on 02/14/23 at 3:55 PM who confirmed that she was working on 12/22/22. She stated she was responsible for Resident #1 and another staff member who she could not recall notified her that Resident #1's PICC line was out. Nurse #1 stated she went to Resident #1's room and found his PICC line lying on the floor at the foot of Resident #1's bed. Nurse #1 stated she measured the PICC line to 45 centimeters and placed the line in a bag and gave to Nurse #2 and instructed her to call the MD to get the IV line replaced. Nurse #1 confirmed that she had not called the MD or the Infectious Disease Provider, she stated she left the PICC line with Nurse #2 and instructed her to notify the MD to get the IV line replaced. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a physician order dated 12/23/22 read, obtain peripheral line due to antibiotic use. The order was electronically signed by Nurse #3 and the Medical Director (MD). Nurse #3 was interviewed via phone on 02/15/23 at 4:56 PM. Nurse #3 stated that she recalled Resident #1 as he was on IV antibiotics that ran for twenty-four hours at a time. She stated she was not on shift when his PICC line got pulled out and could not recall if the IV line got reinserted or not. Nurse #3 could not recall why or how she obtained the order dated 12/23/22 to obtain a peripheral IV line for antibiotic use for Resident #1. She confirmed that she had not notified the MD or the Infectious Disease Provider that Resident #1's PICC was out or to obtain any new orders. The MD was interviewed on 02/15/23 at 10:03 AM who stated that he had been the MD at the facility since June 2022 and was at the facility once a week. The MD stated that he was not at all familiar with Resident #1 as he never evaluated him while he was in the facility. He indicated that the Telemed Physician (a physician who evaluates a resident via computer or electronic device) had evaluated Resident #1 and maybe she could answer questions regarding Resident #1. The MD stated that if he had a resident who was receiving IV antibiotic via a PICC line and was being followed by Infectious Disease he would prefer to consult with them regarding any issues with the IV antibiotic or PICC line. A follow up interview via phone was conducted with the MD on 02/15/23 at 8:42 PM. The MD stated that he recalled getting a call from a nurse on 12/22/22 but he could not recall which nurse regarding Resident #1's PICC line coming out. The MD stated he used his judgement to just observe Resident #1. The MD indicated he provided no further orders that night and he thought at that point it was a better option to just observe him and if he deteriorated then we would get some lab work. The MD stated, looking back I should have done things differently. He further confirmed that he did not refer the nursing staff to the Infection Disease provider as he previously stated he would do. The MD again stated he thought it was best to just observe Resident #1. The Regional Medical Director was interviewed on 02/15/23 at 11:50 AM via phone who stated he was not familiar with Resident #1 but stated if a resident was on IV antibiotic it was for good reason and would be important if the resident missed doses of the IV antibiotic. He further stated that he had reviewed Resident #1's medical record and it did not appear that any provider was made aware that Resident #1's PICC line was out. The Telemed Physician was interviewed via phone on 02/15/23 at 11:18 AM. The Telemed Physician stated she really could not recall Resident #1. She stated she did not take call for the facility and was not notified Resident #1's PICC line came out. She stated that generally if she was not the provider that initiated the antibiotic therapy, she was not going to alter it, that would need to go through the provider that ordered the medication and in this case was the Infectious Disease Provider. She further stated had someone called her she would have had the staff contact the Infectious Disease Provider and then try to figure out how to get the resident the next dose of scheduled antibiotic as quickly as possible. Nurse #4 was interviewed via phone on 02/15/23 at 2:43 PM. Nurse #4 stated that he recalled Resident #1 and recalled that he was on IV antibiotics. Nurse #4 stated he was told in report on 12/25/22 that Resident #1 had pulled his PICC line out and they were waiting for it to be replaced. Nurse #4 stated he could not confirm that the IV was ever replaced and stated he had not contacted the MD or the Infectious Disease Provider for any additional orders. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Nurse #2 was interviewed via phone on 02/16/23 at 2:39 PM. Nurse #2 stated she vaguely recalled Resident #1 and him pulling his PICC line out. She stated she had not called the MD to get any alternate medication or antibiotics as she was not familiar with which antibiotics Resident #1 was on, why he was on it, or the duration of his treatment of those antibiotics. Nurse #2 stated if the PICC line came out on her shift she would assess the resident and notify the MD but Resident #1's PICC line came out on the shift before hers and she assumed that had all been taken care of. Nurse #2 confirmed that she had not had any communication with the Infectious Disease Provider at all. She stated if I called the IV company then I am sure that I texted the MD to let them know that he had pulled the PICC line out and I was getting it replaced but could not recall which provider. Nurse #2 again stated that Resident #1's PICC line came out on Nurse #1's shift and it would have been her responsibility to notify the MD that the line came out and obtain any new orders. The Director of Nursing (DON) was interviewed on 02/15/23 at 3:58 PM who stated she vaguely recalled Resident #1. She stated he was on IV antibiotics and his PICC line that was used for administration of those IV antibiotics got pulled out. The DON stated that when PICC's line became dislodged the provider was immediately notified but she did not know which provider was notified regarding Resident #1's PICC line. She stated sometimes they got a hold order to just hold the antibiotic until the IV line can be replaced but they could also get an order to give another antibiotic via a different route like intramuscularly until the IV line could be replaced. The DON was not aware of any additional orders that were obtained regarding the IV Oxacillin. The Infectious Disease Provider was interviewed via phone on 02/15/23 at 1:50 PM who stated she was very familiar with Resident #1 as she had followed him several days while he was in the hospital before coming to the facility. She indicated that Resident #1 was on IV Oxacillin for a specific organism that was detected on a culture that was obtained. The Infectious Disease Provider stated that her office had contacted Resident #1's nurse at the facility on 12/22/22 at 10:04 AM to confirm that the facility had the correct order for the IV antibiotic, the correct duration for the antibiotics, and that they had orders for the required weekly blood work that was needed. At no time during that conversation or other time was her office made aware that Resident #1's PICC line was out, and he was not receiving his IV Oxacillin. The Infectious Disease Provider also explained that Resident #1 was on day 19 (4 at the facility and 15 at the hospital) of his entire six-week course of antibiotic indicating he was not just starting his course of therapy, but he had not reached the halfway point in his therapy. The Infectious Disease Provider stated that if she would have been made aware she would have immediately intervened by bringing Resident #1 back to the emergency room , getting his IV access replaced while simultaneously administering a different antibiotic via a different route. The Administrator was notified of the immediate jeopardy on 02/15/23 at 5:20 PM. The facility provided the following IJ removal plan: F580: Identify those residents who have suffered, or likely to suffer, a serious adverse outcome as a result of the noncompliance: Resident #1 did not receive IV antibiotics on 12/22/22, 12/23/23, 12/24/23, and 12/25/23 secondary to IV access becoming dislodged. The infectious disease provider was not notified the access was dislodged and the antibiotics were not received. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 02/15/23, the Director of Nursing reviewed resident's medications for administration compliance and notification to the provider for any missed administrations. Any opportunities identified during this audit will be addressed by 02/16/23. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete: On 02/15/23, the Director of Nursing educated licensed nurses on requirements to notify the MD when medication cannot be administered as ordered. Education was also completed on notifying the provider in the event the IV access becomes dislodged. The MD will be notified by phone at the time medication is not given. The Director of Nursing will ensure no licensed nurses will work without receiving this education. Any new hires including agency will receive education prior to the beginning of their first shift. Education will be completed on 02/16/2023 by Director of Nursing or Unit Manager. The Chief Nursing Officer educated the Administrator and Director of Nursing on 02/15/23 regarding the clinical morning meeting process to include reviewing MD notification of missed medications and dislodged IV access. Effective 02/15/2023, the Administrator will be responsible to ensure implementation of this IJ removal plan for this alleged non-compliance. The alleged date of IJ removal is 02/17/2023. A credible allegation validation of notification was conducted in the facility on 02/20/23. The education provided to the licensed nurses in the facility including Nurse #1, Nurse #2, Nurse #3, and Nurse #4 was reviewed. The interviews revealed that the licensed nurses had been trained on the process of notification and immediately reporting to the medical provider when medications could not be given in the way they were ordered. The facility conducted a root cause analysis to help identify issues and was reviewed without concern. The facility's immediate jeopardy removal date of 02/17/23 was validated.

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43643 Based on record review and staff interview the facility neglected to resume Resident #1's intravenous (IV) antibiotic when his IV access was restored for 1 of 1 resident (Resident #1) reviewed and they also failed to provide scheduled bed baths as requested. The residents expressed feelings of being dirty, unhappy, itchy, and unclean for 2 of 3 residents reviewed for neglect (Resident #7 and Resident #6). The findings included: 1. Resident #7 was admitted to the facility on [DATE] with diagnoses of hypertension and muscle weakness. A review of the admission Minimum Data Set (MDS) dated [DATE] indicated Resident #7 was cognitively intact. The MDS revealed Resident #7 was total dependent and required two staff assist for bathing. The MDS also indicated it was very important to for Resident #6 to choose between a tub bath, shower, or bed bath. An interview and observation with Resident #7 on 2/14/23 at 10:15 AM revealed she had not received consistent showers as scheduled since admission. Resident #7 further revealed she preferred bed baths and had to ask nursing staff on weekends to receive one. Resident #7 stated she felt unclean, and her hair felt dirty and had expressed this to staff multiple times. Observation revealed Resident #7 to have greasy and tangled hair and have facial expressions of being unhappy. An interview with Nurse Aide (NA) #1 on 02/15/23 at 2:05 PM revealed she worked on the shower team for the facility but was often pulled to the floor to assist other NAs due to short staffing. NA #1 further revealed Resident #7 had missed preferred bath baths multiple days and had complained of feeling nasty. NA #1 stated multiple residents had complained showers and baths were not being given as scheduled as preferred. An interview with NA #5 on 02/15/23 at 2:15 PM revealed assisted NA #1 with showers and baths and Resident #7 had not refused. NA #5 indicated the facility sometimes did not have enough NAs so staff assisting with showers would get pulled to the floor. NA #5 stated Resident #7 had expressed she had felt dirty at time due to not receiving a scheduled bed bath. An interview with Unit Manager (UM) #1 on 02/15/23 at 12:05 PM revealed she did not recall Resident #7 had refused preferred bed baths before. UM #1 further revealed NA's completing showers and baths had been pulled to the floor to assist other NAs due to staff who had called out. UM #1 indicated she was not aware #7 had missed multiple bed baths as scheduled and expressed feelings of being unclean. An interview with the Director of Nursing (DON) on 02/15/23 at 12:30 PM revealed Resident #7 preferred a bad bath and was not aware that she had missed several scheduled days and complained of feeling dirty. The DON further revealed she expected for Resident #7 and other residents to receive their shower or bath on scheduled days and to feel clean and comfortable. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	3. Resident #6 was admitted to the facility on [DATE] with diagnoses of hypertension, and arthritis. A review of the admission Minimum Data Set (MDS) dated [DATE] indicated Resident #6 was cognitively intact. The MDS further revealed Resident #6 was total dependent and required two staff assist for bathing. The MDS also indicated it was very important to for Resident #6 to choose between a tub bath, shower, or bed bath. An interview and observation with resident #6 on 2/14/23 at 1:00 PM revealed he had not received consistent showers as scheduled since admission. Resident #6 further revealed he preferred bed baths and had told nursing staff he had not received preferred bed baths. Resident #6 stated he felt dirty and itchy and wanted his bed baths as scheduled and had expressed this to nursing staff. Observation revealed Resident #6 to have an odor. An interview with NA #1 on 02/15/23 at 2:05 PM revealed she worked on the shower team consistently for the facility but was often pulled to the floor to assist other NAs due to short staffing. NA #1 further revealed Resident #6 had missed preferred bath baths multiple days and had complained of feeling dirty. NA #1 stated multiple residents had complained showers and baths were not being given as scheduled as preferred. An interview with NA #5 on 02/15/23 at 2:15 PM revealed assisted NA #1 with showers and baths and Resident #6 had not refused. NA #6 indicated the facility sometimes did not have enough NAs so staff assisting with showers would get pulled to the floor. NA #5 stated Resident #6 and other residents had complained they had not received showers or baths as scheduled. An interview with Unit Manager (UM) #1 on 02/15/23 at 12:05 PM revealed she did not recall Resident #6 had refused preferred bed baths and had expressed he had felt dirty. UM #1 further revealed NAs completing showers and baths had been pulled to the floor to assist other NA's due to staff who had called out. UM #1 indicated she was not aware #6 had missed multiple bed baths as scheduled. An interview with the Director of Nursing (DON) on 02/15/23 at 12:30 PM revealed Resident #6 preferred a bad bath and was not aware that he had missed several scheduled days and complained of feeling dirty. The DON further revealed she expected for Resident #6 and other residents to receive their shower or bath on scheduled days and to feel clean and comfortable. 35789 2. Resident #1 was admitted to the facility on [DATE] with diagnoses that included: brain metastasis (cancer that has spread to the brain), chronic subdural hematoma, and sepsis. Review of a physician order dated 12/18/22 read, Oxacillin (antibiotic) 10 grams (gm) reconstituted. Use 12 gm IV one time a day for encephalitis/sepsis for 27 days. Infuse 12 gm over a 24-hour period. Review of the Medication Administration Record (MAR) dated 12/2022 indicated that Oxacillin was given as ordered on 12/18/22, 12/19/22, 12/20/22, and 12/21/22. The MAR indicated that Oxacillin was not administered on 12/22/22, 12/23/22, 12/24/22, and 12/25/22. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of a nurse's note dated 12/22/23 at 7:34 AM written by Nurse #1 read, made aware that resident's PICC line was out and at the foot of the bed. Per resident he got caught up turning in bed and must have pulled it out. On coming nurse made aware for replacement. Review of a nurse's note dated 12/22/23 at 9:56 AM written by Nurse #2 read, IV company called, stated a central line (type of IV line) would be appropriate and a nurse would call shortly to establish when it could be done. Review of a MAR administration note dated 12/24/22 at 11:31 AM and written by Nurse #2 read, Oxacillin, no iv access, IV replacement to be done today. Review of documentation from an external IV company indicated that on 12/24/22 at 3:48 PM they arrived at the facility and inserted an IV access in Resident #1's right hand. The line was secured and flushed, and Resident #1 tolerated procedure well. Review of a MAR administration note dated 12/25/22 at 9:59 AM and written by Nurse #4 read, Oxacillin, waiting for IV insertion. Nurse #1 was interviewed via phone on 02/14/23 at 3:55 PM who confirmed that she was working on 12/22/22. She stated she was responsible for Resident #1 and another staff member who she could not recall notified her that Resident #1's PICC line was out. Nurse #1 stated she placed the IV line in a bag and gave it to Nurse #2 and instructed her to call the Medical Director (MD) to get the IV line replaced. Nurse #2 was interviewed via phone on 02/16/23 at 2:39 PM. Nurse #2 stated she vaguely recalled Resident #1 and him pulling his PICC line out. She stated if she documented that she called to have it replaced then she had done so. Nurse #2 could not recall if she attempted to reinsert the IV line or not nor could she recall if the external IV company came to replace the IV line. Nurse #2 stated that the external IV company usually let someone know that they were there to replace an IV line. Nurse #2 confirmed that Resident #1's Oxacillin was not administered on 12/22/22 or on 12/24/22 because his PICC line had been pulled out. Nurse #4 was interviewed via phone on 02/15/23 at 2:43 PM. Nurse #4 stated that he recalled Resident #1 and recalled that he was on IV antibiotics. Nurse #4 stated that he was off for a few days and when he came back, he was told in report on 12/25/22 that Resident #1 had pulled his PICC line out and we were waiting for it to be replaced. Nurse #4 stated he could not confirm that the IV was ever replaced. Nurse #4 confirmed that Resident #1's IV had not been pulled out on his shift and to his knowledge the line was never replaced and that was why his IV Oxacillin was not given on 12/25/22. The Director of Nursing (DON) was interviewed on 02/20/23 at 12:50 PM. The DON stated that on 12/22/22 Resident #1's PICC line got pulled out and Nurse #2 had called for it to be replaced. She stated that they learned that the IV was replaced on 12/24/22. The DON stated that as soon as the IV line was restored Resident #1's IV Oxacillin should have been restarted. The DON stated she was at loss at what happened on 12/24/22 and 12/25/22 about why Resident #1 did not receive his IV antibiotic and stated she was not getting a lot of information about that. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The Infectious Disease Provider was interviewed via phone on 02/15/23 at 1:50 PM who stated she was very familiar with Resident #1 as she had followed him several days while he was in the hospital before coming to the facility. She indicated that Resident #1 was on IV Oxacillin for a specific organism that was detected on a culture that was obtained. She further explained that Oxacillin's affects peaked at thirty minutes which was why in the hospital setting it was given very frequently but in the skilled nursing facility it was infused over a twenty-four-hour period. The Infectious Disease provider stated that once Resident #1's IV access had been restored his IV Oxacillin should have immediately been restarted as ordered.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35789 Based on record review and staff interview the facility failed to develop a baseline care plan that included a peripherally inserted central catheter (PICC) (IV used to administer IV medications) and the use of IV antibiotic for 1 of 1 residents reviewed (Resident #1). The findings included: Resident #1 was admitted to the facility on [DATE] with diagnoses of that included: brain metastasis (cancer that has spread to the brain), chronic subdural hematoma, and sepsis. Review of Physician order dated 12/17/22 read IV PICC line monitor every shift for signs or symptoms of infection or infiltration. Review of a Physician order dated 12/18/22 read, Oxacillin (antibiotic) 10 grams (gm) reconstituted. Use 12 gm IV one time a day for encephalitis/sepsis for 27 days. Infuse 12 gm over a 24-hour period. Review of Resident #1's baseline care plan dated 12/17/22 revealed no information regarding Resident #1's IV medication or his PICC line. The last page of the document had a box that read, Special Services/Instructions: none. The baseline care plan was completed by Nurse #3 and signed by the Director of Nursing (DON). Nurse #3 was interviewed on 02/17/23 at 12:39 PM via phone. Nurse #3 confirmed that she had completed the baseline care plan for Resident #1. She stated that the baseline care plan was basically an assessment that she checked the boxes if it was applicable to the resident. She stated that the baseline care plan did not contain a section regarding IV medications or PICC lines and she did not believe that there was a place to add that information. Nurse #3 further stated that the information regarding IV medication and PICC line could be added through the daily nursing assessment. The DON was interviewed on 02/20/23 at 12:50 PM. She stated that the baseline care plan was started by the admission nurse and then one of the supervisors would sign to complete the baseline care plan. The DON stated that the baseline care plan did not have a specific section for IV medication or PICC lines but that information should be added to the special services/instructions box at the end of the document. She stated that anything that was required to care for the resident that was not included the other sections of the document should be added at the end of the document in the section titled special services/instruction.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37280 Based on observations, record reviews, staff and Resident interviews the facility failed to provide dependent residents with showers for 3 of 6 residents (Resident #2, Resident #6, Resident #7) reviewed for activities of daily living. The finding included: 1. Resident #2 was admitted to the facility on [DATE] with diagnoses that included coronary artery disease and intervertebral disc disorder sustained in a motor vehicle accident. The annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #2 was cognitively intact and required total assistance with bathing. The MDS also indicated the Resident was frequently incontinent of bladder and bowel and had no behaviors of rejection of care. The care plan dated 05/31/22 revealed Resident #2 had a self-care deficit related to chronic back pain with the goal to improve current level of functioning by utilizing interventions such as encouraging the resident to wash her face. Review of the shower schedule revealed Resident #2 was scheduled for showers on Tuesday and Friday during the 7 AM to 7 PM shift. Review of the shower notebook revealed the last shower Resident #2 received on a Tuesday was January 24th, 2023. Review of Resident #2's Activity of Daily Record (ADL) revealed the Resident did not receive a shower, as assigned on Tuesday 02/07/23 and Tuesday 02/14/23. On 02/14/23 at 10:30 AM during an observation and interview with Resident #2 revealed she was lying in bed with no odors and her hair appeared dry and matted. The Resident expressed that she was waiting to see if she was going to get her shower that day (Tuesday). The Resident explained that she was supposed to get two showers a week (Tuesday and Friday) but lately she had only been getting one shower a week which was on Fridays. She explained that when she asked the staff about her showers on Tuesdays she was told by the girls that there were not enough staff to give all the showers. The Resident continued to explain that she understood that it was hard to get people to work but she was used to taking two or three showers a week at home and would like to continue taking at least two showers a week at the facility especially since she spilled food on herself when she fed herself and had accidents in her briefs. Resident #2 stated she enjoyed her showers and never refused them. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/15/23 at 11:40 AM an interview was conducted with Nurse Aide (NA) #1 who explained that the facility scheduled a shower team every day that consisted of two nurse aides to provide showers from 7:00 AM to 7:00 PM and the shower list could be up to 30 residents on the list. The NA confirmed that she and NA #2 were assigned to give showers on Tuesday (02/07/23) but NA #2 only worked until 3:00 PM that day and she had the rest of the residents on the list to shower by herself therefore, she could not get to everyone on the list. The NA explained that the shower list could have up to 30 residents a day scheduled for showers and that did not include the showers that were left over from the day before or the extra showers that management directed them to give so it was impossible to complete all the showers that were due. The NA stated Resident #2 never refused her showers and that she enjoyed taking her showers. During an interview with Nurse Aide (NA) #2 on 02/15/23 at 2:55 PM the NA explained that she was assigned to give showers often and when she was the facility was aware that she could only work until 3:00 PM. NA #2 confirmed she was scheduled to give showers with NA #1 on Tuesday, 02/07/23, but she was only scheduled to work till 3:00 PM. The NA explained that when she was scheduled to give Resident #2 her showers that she was always agreeable to taking her showers. An interview was conducted with Nurse Aide (NA) #3 on 02/15/23 at 2:45 PM who was assigned to give showers on Tuesday, 02/14/23 but she was unable to give Resident #2 her shower because her partner which was NA #4 was pulled to the floor to work, and she could not give all the showers that were left. The NA stated Resident #2 enjoyed taking her showers and never refused them. Attempts were made to interview Nurse Aide #4 but were unsuccessful. During an interview with the Administrator in the presence of the Director of Nursing on 02/15/23 at 4:45 PM, the Administrator explained that the residents should be able to receive as many showers as they wanted and that they were looking at different ways to simplify the shower workload. 43643 2. Resident #7 was admitted to the facility on [DATE] with diagnoses of hypertension and muscle weakness. A review of the admission Minimum Data Set (MDS) dated [DATE] indicated Resident #7 was cognitively intact. The MDS revealed Resident #7 was total dependent and required two staff assist for bathing. The MDS also indicated it was very important for Resident #6 to choose between a tub bath, shower, or bed bath. Review of the facility shower log documented Resident #7 was scheduled to receive showers on Wednesday and Sundays. The shower log further documented Resident #6 had only received a bed bath on 01/01/23, 01/04/23, 01/08/23, 01/25/23, 01/29/23, and 02/12/23. The documentation was reviewed from 01/01/23 through 02/13/23. An interview and observation with Resident #7 on 2/14/23 at 10:15 AM revealed she had not received consistent showers as scheduled since admission. Resident #7 further revealed she preferred bed baths and had to ask nursing staff on weekends to receive one. Resident #7 stated she felt unclean, and her hair felt dirty. Observation revealed Resident #7 to have greasy and tangled hair. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with Nurse Aide (NA) #1 on 02/15/23 at 2:05 PM revealed she worked on the shower team for the facility but was often pulled to the floor to assist other NAs due to short staffing. NA #1 further revealed Resident #7 had missed preferred bath baths multiple days and had complained of feeling nasty. NA #1 stated multiple residents had complained showers and baths were not being given as scheduled as preferred. An interview with NA #5 on 02/15/23 at 2:15 PM revealed NA #1 assisted with showers and baths and Resident #7 had not refused. NA #5 indicated the facility sometimes did not have enough NA ' s so staff assisting with showers would get pulled to the floor. NA #5 stated Resident #6 and other residents had complained they had not received showers or baths as scheduled. An interview with Unit Manager (UM) #1 on 02/15/23 at 12:05 PM revealed she did not recall Resident #7 had refused preferred bed baths before. UM #1 further revealed NAs completing showers and baths had been pulled to the floor to assist other NAs due to staff who had called out. UM #1 indicated she was not aware Resident #7 had missed multiple bed baths as scheduled. An interview with the Director of Nursing (DON) on 02/15/23 at 12:30 PM revealed Resident #7 preferred a bad bath and was not aware that she had missed several scheduled days. The DON further revealed she expected for Resident #7 and other residents to receive their shower or bath on scheduled days. 3. Resident #6 was admitted to the facility on [DATE] with diagnoses of hypertension, and arthritis. A review of the admission Minimum Data Set (MDS) dated [DATE] indicated Resident #6 was cognitively intact. The MDS further revealed Resident #6 was total dependent and required two staff assist for bathing. The MDS also indicated it was very important to for Resident #6 to choose between a tub bath, shower, or bed bath. Review of the facility shower log documented Resident #6 was scheduled to receive showers on Wednesday and Saturdays. The shower log further documented Resident #6 had only received a bed bath on 01/14/23, 01/18/23, 01/21/23, 01/25/23, and 02/04/23. The documentation was reviewed from 01/01/23 through 02/13/23. An interview and observation with resident #6 on 2/14/23 at 1:00 PM revealed he had not received consistent showers as scheduled since admission. Resident #6 further revealed he preferred bed baths and had told nursing staff he had not received preferred bed baths. Resident #6 stated he felt dirty and itchy and wanted his bed baths as scheduled. Observation revealed Resident #6 to have an odor. An interview with NA #1 on 02/15/23 at 2:05 PM revealed she worked on the shower team consistently for the facility but was often pulled to the floor to assist other NAs due to short staffing. NA #1 further revealed Resident #6 had missed preferred bath baths multiple days and had complained of feeling dirty. NA #1 stated multiple residents had complained showers and baths were not being given as scheduled as preferred. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with NA #5 on 02/15/23 at 2:15 PM revealed assisted NA #1 with showers and baths and Resident #6 had not refused. NA #5 indicated the facility sometimes did not have enough NAs so staff assisting with showers would get pulled to the floor. NA #5 stated Resident #6 and other residents had complained they had not received showers or baths as scheduled. An interview with Unit Manager (UM) #1 on 02/15/23 at 12:05 PM revealed she did not recall Resident #6 had refused preferred bed baths before. UM #1 further revealed NAs completing showers and baths had been pulled to the floor to assist other NAs due to staff who had called out. UM #1 indicated she was not aware #6 had missed multiple bed baths as scheduled. An interview with the Director of Nursing (DON) on 02/15/23 at 12:30 PM revealed Resident #6 preferred a bad bath and was not aware that she had missed several scheduled days. The DON further revealed she expected for Resident #6 and other residents to receive their shower or bath on scheduled days.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 37280 Based on observations, record reviews, staff, and Resident interviews the facility failed to provide sufficient nursing staff resulting in residents not being treated in a dignified manner and missed showers for 3 of 6 sampled residents (Resident #2, #6 and #7). The findings include: This tag is crossed referenced to F 550: Based on record reviews, observations and resident and staff interviews, the facility failed to treat residents in a dignified manner when staff did not provide scheduled bed baths requested. The resident expressed feelings of being dirty, unhappy, itchy, and unclean. This affected 2 of 3 residents reviewed for dignity and respect (Resident #7 and Resident #6). This tag is crossed referenced to F 677: Based on observations, record reviews, staff and Residents' interviews the facility failed to provide dependent residents with showers for 3 of 6 residents (Resident #2, Resident #6, Resident #7) reviewed for activities of daily living. On 02/15/23 at 2:45 PM during an interview with Nurse Aide (NA) #3 she explained that the facility scheduled a bathing team which consisted of 2 nurse aides to give showers or bed baths every day from 7 AM to 7 PM. The NA continued to explain that she was normally assigned to provide showers unless there were not enough nurse aides to cover the halls due to call outs or no calls and no shows then in that case one or both nurse aides assigned to give showers would be pulled to the hall and the hall staff would be responsible for providing the scheduled showers or bed baths whichever the case. The NA indicated more times than not the showers were not able to be provided because of the workload on the hall with residents and in that case the residents would be added to the shower list for the next day. The NA explained that the shower list for any given day could contain up to 30 residents and that did not include the added residents from the day prior. The NA stated it was frequent that one or both nurse aides assigned to give showers were pulled to the hall to work. She also explained that other factors that prevented them from providing scheduled showers were several residents required two people shower assist and required a timeframe of up to two hours to give showers which also took up a lot of time and the shower team could not shower during mealtimes because of the residents eating. An interview was conducted with Nurse #5 on 02/20/23 at 10:39 AM. The Nurse explained staffing is horrible. The facility schedules enough help, but the agency staff cancels the shifts especially on the weekends and it is almost impossible to get everything done. The showers, mouth care and nail care were not getting done because there was not enough staff. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with Medication Aide (MA) #1 on 02/20/23 at 10:43 AM who explained that staffing was great when the agency staff showed up to work, but they had a lot of agency staff that did not show up or they would call out and that made getting resident care done very difficult. The MA continued to explain when they were fully staffed the shower team was able to complete the showers but when the shower team were pulled to the floor then the showers did not get done. An interview was conducted with the Administrator on 02/20/23 at 1:45 PM. The Administrator explained the facility was difficult to staff because of issues like nearby plants offering higher wages and the facility being located in a rural area. The facility utilized nine different staffing agencies but when call outs and no calls or no shows happen especially at night it was difficult to find coverage. The Administrator continued to explain that the facility utilized two rehab nurse aides six days a week along with the shower team seven days a week and the rehab nurse aides were pulled to the hall to work before the shower team was pulled to the hall. Worst case scenario the Administrator stated, if need be, the department heads could come to the facility and take care of the residents.

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35789 Based on record review, staff, Regional Medical Director, Medical Director, and Infectious Disease Provider interviews the facility failed to prevent a significant medication error when staff failed to administer ordered doses of an IV antibiotic on [DATE] and [DATE]. The Peripherally Inserted Central Catheter (PICC) (intravenous (IV) line used to administer IV antibiotics) line was replaced with a different type of IV access on [DATE] and the staff failed to administer the IV antibiotic on [DATE] and [DATE] for 1 of 1 resident (Resident #1) reviewed for significant medication errors. There was the high likelihood for bacterial regrowth, resistance to antibiotic, sepsis, or return to hospital due to the missed medications. Immediate jeopardy began on [DATE] when staff failed to administer 4 doses of Resident #1's IV antibiotics. Immediate jeopardy was removed on [DATE] when the facility provided an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems are in place and the completion of employee education. The findings included: Resident #1 was admitted to the facility on [DATE] with diagnoses that included: brain metastasis (cancer that has spread to the brain), chronic subdural hematoma, and sepsis. The physician order dated [DATE] read, Oxacillin (antibiotic) 10 grams (gm) reconstituted. Use 12 gm IV one time a day for encephalitis/sepsis for 27 days. Infuse 12 gm over a 24-hour period. The Medication Administration Record (MAR) dated ,d+[DATE] indicated that Oxacillin was given as ordered on [DATE], [DATE], [DATE], and [DATE]. The MAR indicated that Oxacillin was not administered on [DATE], [DATE], [DATE], and [DATE]. The nurse's note dated [DATE] at 7:34 AM written by Nurse #1 read, made aware that resident's PICC (IV line used to administer IV antibiotics) line was out and at the foot of the bed. Writer noted PICC line of 45 centimeters on the floor and asked resident what happened. Per resident he got caught up turning in bed and must have pulled it out. Oncoming nurse made aware for replacement. Nurse #1 was interviewed via phone on [DATE] at 3:55 PM who confirmed that she was working on [DATE]. She stated she was responsible for Resident #1 and another staff member who she could not recall notified her Resident #1's PICC line was out. Nurse #1 stated she was finishing her shift and was ready to clock out, but she went to Resident #1's room and found his PICC line lying on the floor at the foot of Resident #1's bed. Resident #1 was unable to conversate with Nurse #1 and could not recall what had occurred. Nurse #1 stated she measured the PICC line to 45 centimeters and placed the line in a bag and gave to Nurse #2 and instructed her to call the Medical Director (MD) to get the IV line replaced. She added Resident #1's arm was not bleeding and did not require any additional treatment and then she left the facility because her shift was over. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A nurse's note dated [DATE] at 9:56 AM written by Nurse #2 read, IV company called, stated a central line (type of IV line) would be appropriate and a nurse would call shortly to establish when it could be done. Nurse #2 was interviewed via phone on [DATE] at 2:39 PM. Nurse #2 stated she vaguely recalled Resident #1 and him pulling his PICC line out. She stated if she documented that she called to have it replaced then she had done so but had not called the MD to get any alternate medication or antibiotic as she was not familiar with which antibiotics Resident #1 was on, why he was on it, or the duration of his treatment of those antibiotics. Nurse #2 stated if the PICC line came out on her shift she would assess the resident and notify the MD but Resident #1's PICC line came out on the shift before hers and she assumed that had all been taken care of. Nurse #2 could not recall if she attempted to reinsert the IV line or not. Nurse #2 confirmed that Resident #1's Oxacillin was not administered on [DATE] because his PICC line had been pulled out. The MAR administration note dated [DATE] at 1:15 PM and written by Nurse #3 read, Oxacillin, unable to give at this time due to resident pulling out PICC line and waiting on IV access to come and place peripheral line. Nurse #3 was interviewed via phone on [DATE] at 4:56 PM. Nurse #3 stated that she recalled Resident #1 as he was on IV antibiotic that ran for twenty-four hours at a time. She stated she was not on shift when his PICC line got pulled out and could not recall if the IV line got reinserted or not. Nurse #3 confirmed that on [DATE] she did not administer Resident #1's Oxacillin because his PICC line had been pulled out and he did not have IV access. Nurse #3 stated that she knew that someone had called for the IV line to be replaced could not recall if she had attempted to reinsert the IV or not. She also confirmed she had not contacted any provider for any additional orders regarding the Oxacillin. The MAR administration note dated [DATE] at 11:31 AM and written by Nurse #2 read, Oxacillin, no iv access, IV replacement to be done today. A document from an external IV company indicated that on [DATE] at 3:48 PM they arrived at the facility and inserted an IV access in Resident #1's right hand. The line was secured and flushed, and Resident #1 tolerated procedure well. The MAR administration note dated [DATE] at 9:59 AM and written by Nurse #4 read, Oxacillin, waiting for IV insertion. Nurse #4 was interviewed via phone on [DATE] at 2:43 PM. Nurse #4 stated that he recalled Resident #1 and recalled that he was on IV antibiotics. Nurse #4 stated that he was off for a few days and when he came back, he was told in report on [DATE] that Resident #1 had pulled his PICC line out and they were waiting for it to be replaced. Nurse #4 stated he could not confirm that the IV was ever replaced and stated he had not contacted the MD because someone had already done that, nor had he attempted to reinsert the IV because they were waiting on the IV company to come and reinsert the IV. Nurse #4 also stated that Resident #1 had not pulled his IV out during his shift and was certain that he did not administer the Oxacillin on [DATE] because he did not have an IV because as that was what he was told in report. Resident #1 died on [DATE] in the facility. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #1's death certificate indicated his cause of death to be encephalopathy (a broad term for any brain disease that alters brain function mostly commonly caused by infection). The MD was interviewed on [DATE] at 10:03 AM and stated he had been the MD at the facility since [DATE] and was at the facility once a week. The MD stated he was not at all familiar with Resident #1 as he never evaluated him while he was in the facility. He indicated that the Telemed Physician (a physician who evaluates a resident via computer or electronic device) had evaluated Resident #1 and maybe she could answer questions regarding Resident #1. The MD stated that if he had a resident who was receiving IV antibiotic via a PICC line and was being followed by Infectious Disease he would prefer to consult with them regarding any issues with the IV antibiotic or PICC line. A follow up interview via phone was conducted with the MD on [DATE] at 8:42 PM. The MD stated that he recalled getting a call from a nurse on [DATE] but he could not recall which nurse regarding Resident #1's PICC line coming out. The MD stated he used his judgement to just observe Resident #1. The MD indicated he provided no further orders that night and he thought at that point it was a better option to just observe him and if he deteriorated then we would get some lab work. The MD stated, looking back I should have done things differently. He further confirmed that he did not refer the nursing staff to the Infection Disease provider as he previously stated he would do. The MD again stated he thought it was best to just observe Resident #1. The Regional Medical Director was interviewed on [DATE] at 11:50 AM via phone who stated he was not familiar with Resident #1 but stated if a resident was on IV antibiotic it was for good reason and would be important if the resident missed doses of the IV antibiotic. The Director of Nursing (DON) was interviewed on [DATE] at 3:58 PM who stated she vaguely recalled Resident #1. She stated that he was on IV antibiotics and his PICC line that was used for administration of those IV antibiotics got pulled out. The DON stated it was replaced in the facility by an external IV company. The DON stated that the process for when a PICC line become dislodged was the provider was immediately notified and sometimes we get a hold order to just hold the antibiotic until the IV line can be replaced but we could also get an order to give another antibiotic via a different route like intramuscularly until the IV line could be replaced. The DON stated it was important to get the IV line reinserted as quickly as possible, so the resident did not miss scheduled doses of their medications. The Infectious Disease Provider was interviewed via phone on [DATE] at 1:50 PM who stated she was very familiar with Resident #1 as she had followed him several days while he was in the hospital before coming to the facility. She indicated that Resident #1 was on IV Oxacillin for a specific organism that was detected on a culture that was obtained. She further explained that Oxacillin's affects peaked at thirty minutes which was why in the hospital setting it was given very frequently but in the skilled nursing facility it was infused over a twenty-four-hour period. The Infectious Disease Provider also explained that Resident #1 was on day 19 (4 at the facility and 15 at the hospital) of his entire six week course of antibiotic indicating he was not just starting his course of therapy but he had not reached the halfway point in his therapy. The Infectious Disease Provider stated that from an infectious disease standpoint it was a very significant medication error when Resident #1 missed four doses of the IV Oxacillin. She further stated she would have intervened if she had been aware that his PICC line had become dislodged by assisting with getting IV access reinserted and using a different antibiotic that could have been administered intramuscularly until IV access could be obtained. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Administrator was notified of the immediate jeopardy on [DATE] at 5:20 PM. The facility provided the following IJ removal plan: F760: Identify those residents who have suffered, or likely to suffer, a serious adverse outcome as a result of the noncompliance: Resident #1 was identified as having a medication error. Resident #1's intravenous access line was dislodged on [DATE] and he was not administered his IV antibiotics (Oxacillin) as ordered on [DATE], [DATE]. [DATE], and [DATE]. Resident #1 was admitted to the facility on [DATE] with diagnoses included but not limited to viral encephalitis, nontraumatic chronic subdural hemorrhage, type II diabetes, malignant neoplasm of lung, and secondary malignant neoplasm of brain. On [DATE], the Director of Nursing reviewed resident medications for administration compliance. Any opportunities identified during this audit will be addressed by [DATE]. On [DATE], the Director of Nursing reviewed residents with intravenous access. Any opportunities identified during this audit will be corrected by the Director of Nursing by [DATE]. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete: On [DATE], the Director of Nursing educated all licensed nurses on medication administration and the documentation to indicate completion of medication administration. Education also included requirements for notification to the MD for any missed administrations and in the event IV, access becomes dislodged/removed. The MD will be notified by phone at the time medication is not given. The Director of Nursing will ensure no licensed nurses will work without receiving this education. Any new hires including agency will receive education prior to the beginning of their next shift. Education will be completed on [DATE] by Director of Nursing or Unit Manager. The Chief Nursing Officer educated the Administrator and Director of Nursing on [DATE] regarding the clinical morning meeting process to include medication administration and the validation of documentation. Furthermore, education was provided on ensuring the provider is notified in the event the IV access is dislodged. Effective [DATE], the Administrator will be responsible to ensure implementation of this IJ removal plan for this alleged non-compliance. The alleged date of IJ removal is [DATE]. A credible allegation validation of significant medication errors was conducted in the facility on [DATE]. The education provided to the licensed nurses in the facility including Nurse #1, Nurse #2, Nurse #3, and Nurse #4 was reviewed. The interviews revealed that the licensed nurses had been trained on the process of preventing significant medication errors by immediately reporting to the medical providing and either requesting a hold order or additional orders for other medication that could be used. The facility conducted a root cause analysis to help identify issues and was reviewed without concern. The facility immediate jeopardy removal date of [DATE] was validated.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38515 Based on observations and staff and resident interviews, the facility failed to provide palatable food that was appetizing in temperature for 2 of 3 residents reviewed for food concerns. (Resident #7 and Resident #11). The findings included: A. Resident #7 was admitted to the facility on [DATE]. A review of Resident #7's admission Minimum Data Set assessment dated [DATE] revealed Resident #7 to be cognitively intact and needed supervision with eating. During an interview with Resident #7 on 02/15/23 at 1:08 PM, she reported her meal tray was cold and she had eaten about 50% of it. Resident #7 stated the food was typically cold when it was brought to her room and she did not know if it was because it came from the kitchen cold or if it was because the hall staff took too long to pass out the trays. B. Resident #11 admitted to the facility on [DATE]. A review of Resident #11's most recent quarterly Minimum Data Set assessment dated [DATE] revealed Resident #11 to be cognitively impaired for daily decision making. Resident #11 was independent with eating. During an on-site interview with Resident #11's family member, who visited routinely, on 02/15/23 at 12:52 PM, reported she came to the facility daily around lunch time. She stated she had begun to take Resident #11's meal tray off the meal cart when it arrived on the hall because if she waited for Resident #11's meal tray to be brought to his room, his food would be ice cold and he would not eat his meal. An observation of the lunch tray line was conducted on 02/14/22 12:00 PM and a test tray was requested. The test tray which included tomato soup and a grilled cheese sandwich was plated at 12:28 PM and left the kitchen. The test tray arrived on the hall with the other meal trays at 12:32 PM. Staff began passing meal trays at 12:44 PM with the last tray being served at 1:35 PM. Once the final trays were served an observation of the test tray was completed with the Dietary Manager. When the lid was removed there was no steam rising from the soup and the cheese in the grilled cheese sandwich was not melted. The soup was barely warm, and the sandwich had no heat to it, was soggy, and the cheese was no longer melted. The Dietary Manager stated the soup was lukewarm and needed to be hotter and the grilled cheese sandwich was cold and not fresh. She reported she felt the test tray would have been better if served timelier. The Dietary Manager stated over the past couple of weeks, it had felt as though food temperature complaints had increased. She reported it was frustrating because she felt the kitchen had tried to fix the problem even temping the leftover, non-plated food to ensure the temperatures had remained consistent. She reported she felt the lack of urgency by hall staff to pass trays had led to food cooling and being cold when served to the residents. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Administrator, on 02/15/23 at 1:40 PM, she reported she expected resident meal trays to be passed timely to ensure food temperature and quality were appropriate.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 35789 Based on observations, record reviews, and staff interviews, the facility Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions the committee put into place following the recertification and complaint survey conducted on 03/11/20 and 05/26/22 and for the complaint investigation conducted on 03/05/21, 05/07/21, 10/15/21, 09/01/22, and 12/22/21. This failure was for 08 deficiencies that were originally cited in the areas of Resident Rights (F550 and F580) Abuse, Neglect, and Misappropriation (F600), Comprehensive Resident Centered Care plan (F655), Quality of Life (F677), Nursing Services (F725), Pharmacy Services (F760), and Dietary Services (F804) there were subsequently recited on the current complaint investigation survey of 02/20/23. The repeat deficiencies during seven federal surveys of record showed a pattern of the facility's inability to sustain an effective QA program. The findings included: This tag is cross referred to: F550: Based on record reviews, observations and resident and staff interviews, the facility failed to treat residents in a dignified manner when staff did not provide scheduled bed baths requested. The resident expressed feelings of being dirty, unhappy, itchy, and unclean. This affected 2 of 3 residents reviewed for dignity and respect (Resident #7 and Resident #6). During the complaint investigation conducted on 10/15/21 the facility failed to treat residents in a dignified manner by not providing incontinence care prior to a resident wetting through her brief onto her draw sheet. In addition, the facility failed to provide incontinence care to a resident who had a bowel movement prior to dinner and she and her roommate ate dinner while smelling the bowel movement for 3 of 6 residents reviewed for dignity and respect. F580: Based on interview, record review, staff, Medical Director, Telemedicine Physician, Regional Medical Director, and Infectious Disease Provider the facility failed to notify the Infectious Disease Provider that was managing Resident #1's intravenous (IV) antibiotic which was being used to treat a right subdural empyema (collection of pus between the layers of the brain) and Cerebritis (inflammation of cerebrum of the brain) that Resident #1's peripherally inserted central catheter (PICC) (an IV used to administer medications) had become dislodged and his antibiotics were not administered as ordered for 1 of 1 resident reviewed for significant medication errors. There was the high likelihood for bacterial regrowth, resistance to antibiotic, sepsis, or return to hospital due to the missed medications. During the complaint investigation of 03/05/21 the facility failed to notify a physician of an acute change in status immediately following an acute burn sustained by a resident when he was involved in an accident involving smoking while wearing oxygen for 1 of 1 resident reviewed for notification of the medical provider. During the Focused Infection Control and complaint investigation of 09/01/22 the facility failed to notify the physician of medication unavailability for 3 of 3 residents reviewed for medications. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	F600: Based on record review and staff interview the facility neglected to resume Resident #1's intravenous (IV) antibiotic when his IV access was restored for 1 of 1 resident reviewed. During the complaint investigation of 10/15/21 the facility neglected to provide incontinence care to a resident who was soiled with urine and resulted in a small reddish open area on her buttocks for 1 of 4 residents reviewed for activities of daily living. The resident stated that her bottom was burning like it was on fire and wished she could care for herself, so she did not have to sit in a soiled brief. F655: Based on record review and staff interview the facility failed to develop a baseline care plan that included a peripherally inserted central catheter (PICC) (IV used to administer IV medications) and the use of IV antibiotic for 1 of 1 resident reviewed (Resident #1). During the recertification of 03/11/20 the facility failed to complete a baseline care plan within 48 hours of admission for 2 of 4 residents reviewed for pressure ulcers. During the complaint investigation of 05/07/21 the facility failed to develop a baseline care plan in the area of dialysis for 1 of 2 residents reviewed for dialysis and failed to develop a baseline care plan for a resident who required oxygen for 1 of 2 residents reviewed with oxygen. During the complaint investigation of 12/22/21 the facility failed to develop and implement a baseline care plan that addressed the resident's activities of daily living for 1 of 8 residents reviewed for activities of daily living. During the recertification and complaint investigation of 05/26/22 the facility failed to initiate a base line care plan for a resident who was fed through a Gastrostomy tube (GT) and was to have nothing by mouth for 1 of 2 residents reviewed with a GT. F677: Based on observations, record reviews, staff and Residents' interviews the facility failed to provide dependent residents with showers for 3 of 6 residents (Resident #2, Resident #6, Resident #7) reviewed for activities of daily living. During the complaint investigation of 10/15/21 the facility failed to provide incontinence care prior to a resident wetting through her brief onto her draw sheet, failed to provide incontinence care to a resident who had a bowel movement, failed to provide showers as scheduled for 1 resident and failed to provide nail care for 2 residents for 4 of 4 residents reviewed for activities of daily living for dependent residents. During the focused infection control and complaint survey of 09/01/22 the facility failed to provide incontinent care for 1 of 3 residents reviewed for pressure ulcers. F725: Based on observations, record reviews, staff, and Resident interviews the facility failed to provide sufficient nursing staff resulting in residents not being treated in a dignified manner and missed showers for 3 of 6 sampled residents (Resident #2, #6 and #7). (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the complaint investigation of 10/15/21 the facility failed to provide sufficient nursing staff for the provision of incontinence care to a resident who was wet and yelling that it was burning and hurting her skin and as a result ended up with a reddened area on her skin, failed to provide incontinence care to a resident who was wet through her brief and onto her draw sheet, failed to provide incontinence care to a resident who had a bowel movement, failed to provide showers as scheduled for 3 residents and failed to provide nail care for 2 residents for 7 of 7 residents reviewed for sufficient nursing staff. F760: Based on interview, record review, staff, Medical Director, Telemedicine Physician, Regional Medical Director, and Infectious Disease Provider the facility failed to notify the Infectious Disease Provider that was managing Resident #1's intravenous (IV) antibiotic which was being used to treat a right subdural empyema (collection of pus between the layers of the brain) and Cerebritis (inflammation of cerebrum of the brain) that Resident #1's peripherally inserted central catheter (PICC) (an IV used to administer medications) had become dislodged and his antibiotics were not administered as ordered for 1 of 1 resident reviewed for significant medication errors. There was the high likelihood for bacterial regrowth, resistance to antibiotic, sepsis, or return to hospital due to the missed medications. During the complaint investigation of 10/15/21 the facility failed to prevent significant medication errors by not accurately transcribing and administering medication as ordered from the hospital discharge summary prescribed to treat chronic pain, shortness of breath, and anxiety for a hospice resident for 1 of 1 resident reviewed for medication errors As a result, the resident reported her pain level was 7 to 9 on a scale of 1 to 10 across all three shifts during her 4 days as resident in the facility. During the Focused Infection Control and Complaint investigation of 09/01/22 the facility failed to prevent significant medication errors when medications were not obtained and administered per the physician orders for 3 of 3 residents reviewed for medications. F804: Based on observations and staff and resident interviews, the facility failed to provide palatable food that was appetizing in temperature for 2 of 3 residents reviewed for food concerns. (Resident #7 and Resident #11). During the recertification survey of 03/11/20 the facility failed to serve food and coffee at lunch and supper meals that were palatable and at an appetizing temperature for 1 of 2 resident meals sampled for palatability. The Administrator was interviewed on 02/20/23 at 1:32 PM who stated that the facility Quality Assurance (QA) committee met monthly and included all the department heads, the Medical Director, and Consultant Pharmacist. They each reported on the happenings from the previous month to include falls, wounds, pharmacy reports, process improvement plans, and safety issues. She stated they talked about and brainstormed what they could do better going forward to ensure regulatory compliance. The Administrator stated the facility had to get key routine systems that were in place but needed fine tuning and that would keep them on trach for regulatory compliance. The Administrator stated going forward she was going to track the happenings in morning meeting using an excel spreadsheet for high-risk items that they discussed to ensure they were not just reading the information but really deep diving into the issues and discussing them. The Administrator stated she believed that would help the facility get on the track to sustaining compliance long term.