STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345307	A. Building B. Wing	06/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Ivy at Gastonia LLC	4414 Wilkinson Blvd Gastonia, NC 28056

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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 - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 41069 Based on record reviews, and interviews with staff, and Medical Director, the facility failed to notify the Primary Care Provider of significant changes in a resident's condition (Resident #9) when he developed a new opened sacral pressure ulcer, when the pressure ulcer deteriorated and when he continued to have hypotension (low blood pressure) despite receiving intravenous fluids. The facility also failed to report results of a urinalysis and urine culture resulting in a delay in treating the resident (Resident #9) for UTI (urinary tract infection). Resident #9 was hospitalized on [DATE] for severe sepsis/septic shock due to an infected stage 4 pressure ulcer to the sacrum. In addition, the facility failed to notify the Primary Care Provider when a resident had a severe unintended weight loss (Resident #10). Resident #10 had a cumulative weight loss of 24.4% from 1/19/22 through 4/6/22, was admitted to the hospital on 4/7/22 and had a feeding tube inserted in the stomach. These failures were for 2 of 3 residents reviewed for notification of changes (Resident #9 and Resident #10). Immediate Jeopardy began on 3/9/2022 when staff failed to identify a significant weight loss of 11.5% for Resident #10. Resident #10 continued to lose weight and had a cumulative weight loss of 24.4% since 1/19/2022. Immediate Jeopardy began on 3/26/22 for Resident #9 when the facility failed to follow up on urine culture results and provide the care and services required by Resident #9 resulting in a delayed treatment for UTI (urinary tract infection). Resident #9 continued to have confusion, altered mental status, hypotension (low blood pressure) and pressure ulcer deterioration which resulted in Resident #9 being sent out to the emergency room for evaluation and treatment of sepsis due to an infected stage 4 pressure ulcer to the sacrum. The Immediate Jeopardy was removed on 6/18/22 when the facility implemented an acceptable credible allegation for Immediate Jeopardy removal. The facility remains out of compliance at a scope and severity level of E (no actual harm with potential for more than minimal harm that is not immediate jeopardy) for the facility to continue staff education and ensure monitoring systems put into place are effective. The findings included: 1. Resident #9 was admitted to the facility on [DATE] with diagnoses that included hypertension, atrial fibrillation, and peripheral vascular disease. A review of Resident #9's medical record indicated a faxed result from the laboratory dated 3/23/22 at 8:46 PM for a urinalysis with the following abnormal values: cloudy appearance, leukocytes 3+, protein 100, blood 3+, WBC (white blood cells) 3+ and bacteria 3+. (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 - Immediate jeopardy to resident health or safety Residents Affected - Some	A urine culture result reported by the laboratory on 3/26/22 at 11:22 AM indicated Resident #9's urine had a growth of Providencia stuartii of >100,000 cfu (colony-forming unit)/ml (milliliter). The report also outlined the different antibiotics that the organism was susceptible and resistant to. A phone interview with Nurse #2 on 6/13/22 at 2:12 PM revealed she had taken care of Resident #9 on the evening shift when he started to get sick on 3/21/22. Nurse #2 stated she noticed a change in his condition when he called her by another nurses' name, and he was getting more confused. She remembered him receiving intravenous fluids, but she had to hold his blood pressure medication on 3/22/22, 3/23/22, 3/24/22, 3/25/22 and 3/31/22 because his blood pressure was low. Nurse #2 stated at first the low blood pressure reading didn't alert her because Resident #9's blood pressure fluctuated all the time. Nurse #2 also stated she had thought about Resident #9 possibly having sepsis, but she assumed he was being seen by the wound doctor for his pressure ulcer on his sacrum. Nurse #2 further stated she worked on 3/23/22 but didn't remember seeing Resident #9's urinalysis result and was not aware that he had UTI. She couldn't remember if it was passed on during report that they were still waiting on Resident #9's urinalysis and urine culture results. Nurse #2 also stated she had done most of Resident #9's hydrocolloid dressing in March 2022 and she noticed that the open wound on his buttocks had gotten worse, but she didn't remember exactly when it started to get worse. Nurse #2 stated she remembered Resident #9's wound being slightly smaller than the size of a quarter when she started working with him but on 3/30/22 when she had changed his hydrocolloid dressing, she noticed that the wound had gotten bigger to the size of a baseball, and it was draining more. Nurse #2 did not notify the doctor of the worsening of Resident #9's pressure ulcer because she thought he was already being seen by the wound doctor. A phone interview with Nurse #7 on 6/13/22 at 12:18 PM revealed she took care of Resident #9 on 3/24/22 and 3/25/22 and had to change his hydrocolloid dressing on both days. Nurse #7 stated she first saw Resident #9's ulcer to his sacrum on 3/24/22. Nurse #7 stated she observed a quarter-sized open area on Resident #9's bottom that looked clean, pink and had no drainage and no foul odor. Nurse #7 did not report this observation to anyone as she thought this was normal for him. She also did not remember receiving on report that they were waiting on Resident #9's urinalysis and urine culture results. An interview with the Interim Director of Nursing (DON) on 6/13/22 at 10:43 PM revealed Resident #9 had intermittent confusion within the last 4 to 6 weeks when he was at the facility, but she noticed that Resident #9 was a lot more confused on 3/30/22. She stated she looked through Resident #9's medical record on 3/30/22 and discovered a urine culture report dated 3/26/22 that hadn't been addressed. She reported this to the Nurse Practitioner (NP) and requested an order for an antibiotic for the UTI. The Interim DON also stated she was not sure if she had received a report from the nurse before her that they were waiting on Resident #9's urinalysis and urine culture results. A phone interview with Nurse #8 on 6/14/22 at 11:03 AM revealed she took care of Resident #9 on the night shift from 7:00 PM on 3/30/22 to 7:00 AM on 3/31/22. Nurse #8 thought they were still waiting on his urine culture results and was not aware that it had been reported by the laboratory on 3/26/22. Nurse #8 stated things often got trickled down during report between the nurses and not everything got followed up on. She also noted that Resident #9's blood pressure was low, so she held his Metoprolol dose for 8:00 PM. Nurse #8 stated she put a note in the provider's notebook about Resident #9's blood pressure so they could see it when they come the next day. Nurse #8 stated she didn't think it was something she had to report right then and didn't use the electronic message through the tablet to communicate with a provider. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview with Nurse #4 on 6/13/22 at 4:01 PM revealed she took care of Resident #9 on 4/1/22 and had to hold his 8:00 AM Metoprolol dose because his blood pressure was low. Nurse #4 stated Resident #9's low blood pressure didn't alert her because she thought he was receiving intravenous fluids because his blood pressure had been low. A phone interview with Nurse #3 on 6/13/22 at 10:20 AM revealed she took care of Resident #9 from 7:00 AM to 7:00 PM on 4/2/22 and 4/3/22. Nurse #3 recalled seeing the wound on his buttocks on 4/3/22 when she had to change the hydrocolloid dressing. Nurse #3 stated she was surprised to see how bad the wound looked and stated it was the worst-looking pressure ulcer she had ever seen. After Nurse #3 saw the wound, she called the former Director of Nursing (DON) into the room and the former DON placed an antiseptic dressing on the wound. Nurse #3 assumed that the former DON had notified the doctor of Resident #9's pressure ulcer and received an order for the antiseptic dressing. Nurse #3 stated she did not notify the doctor of the pressure ulcer because she had let the former DON know and she thought she was going to take care of it. A phone interview was attempted on 6/13/22 at 12:01 PM, 6/14/22 at 12:00 PM and 6/15/22 at 10:19 AM with the former DON with no return call. A NP note dated 4/5/22 indicated Resident #9 was seen by the NP for the wound to his buttocks. It was documented there was an unstageable wound to one-fourth area of the coccyx, eschar (dead tissue that eventually sloughs off healthy skin after an injury) present to the buttocks and there was also a 2 cm by 2 cm necrotic area to the right heel. Unable to stage wound, recommend he be sent to the hospital for wound evaluation. Multiple attempts were made to contact the NP, but they were unsuccessful. The NP no longer worked with the Medical Director's team. A follow-up interview with the Interim Director of Nursing (DON) on 6/13/22 at 3:00 PM revealed the nursing staff were only supposed to communicate with the providers through text messages through the tablet and the facility did not utilize a notebook for the providers. The Interim DON stated she did not see any documentation/communication regarding Resident #9's worsening condition from 3/22/22 to 4/5/22 except when she had notified the NP of his urine culture results on 3/30/22. The Interim DON also stated that she checked the nurse to physician documented communication text messages and there was no report to the medical staff that Resident #9's wound to his buttocks had opened, was large and black. A phone interview with the Medical Director (MD) on 6/14/22 at 4:22 PM revealed he was aware of open areas on Resident #9's buttocks that recurred due to his non-compliance with offloading and incontinence care, but he wasn't sure about the pressure ulcer that developed right before he was sent out to the hospital. The MD stated he had expected to be notified of any deterioration/decline in pressure ulcers even though they had expected Resident #9's ulcer to get worse due to his non-compliance. The MD also stated he didn't know that there was delay with starting Resident #9 on antibiotics for UTI, but he would have hoped the nursing staff had followed up on the urine culture result, so it was communicated to the NP who had ordered the urinalysis and urine culture. The MD stated he also expected the nurses to have assessed Resident #9 who was acutely ill and checked his vital signs at least once a day. He also expected the nursing staff to report any decline in condition especially the deterioration of Resident #9's pressure ulcer and continued low blood pressure readings even though he was receiving intravenous fluids. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #9's hospital admission notes dated 4/5/22 indicated Resident #9 was seen in the Emergency Department for altered mental status. Resident #9 was found to have severe sepsis/septic shock with acute organ dysfunction, an infected decubitus ulcer stage IV, a pressure injury of buttock stage IV, elevated white blood cells indicating an infection, metabolic encephalopathy, acute renal failure superimposed on chronic kidney disease stage 3, intravascular volume depletion (dehydration), and low sodium. The surgical consult for decubitus sacral ulcer determined the ulcer was large, necrotic, and malodorous ulcer with only minimal erythema. Plan was for surgical debridement and diverting colostomy. It was suspected the sacral ulcer was contaminated with stool. Resident #9 was critically ill and at risk for decompensation resulting in end-organ dysfunction. The resident's fevers were up to 103 Fahrenheit due to an infected sacral pressure ulcer. A CT (computed tomography) scan of the sacral pressure ulcer revealed extensive subcutaneous gas formation (deep seeded infection with gas forming organisms) and tunneling upward within the gluteal and above the gluteal tissues. Resident #9 also had a stage 4 pressure ulcer to the right plantar foot and a soft tissue ulcer to the great toe stump. An interview with the Director of Nursing (DON) on 6/13/22 at 5:34 PM revealed the nurses were supposed to complete weekly skin checks on each resident but if the resident had a pressure ulcer, the nurses were supposed to bring it to the doctor's attention. Any resident with a pressure ulcer should be referred to the wound doctor for proper treatment and evaluation. During a follow-up interview on 6/15/22 at 1:40 PM, the DON also stated that she expected the nurses to follow up on laboratory results and address them with the doctor. The DON further stated she expected the nurses to monitor acutely ill residents by obtaining a full set of vital signs at least once during their shift and to call the doctor about any acute issues or change in condition. The Administrator was notified of Immediate Jeopardy on 6/15/22 at 1:41 PM. 43332 2. Resident #10 was admitted to the facility on [DATE] with diagnosis of cerebral palsy and intellectual disorders. Physician order initiated on 4/21/2021 read in part weekly weights every day shift every Wednesday for weight monitoring. The order was active on resident's discharge date of [DATE]. Resident #10 weighed 125.7 pounds on 1/19/2022 collected by mechanical lift. Review of January 2022 Medication Administration Record (MAR) revealed no documentation of Resident #10's weekly weights from 1/26/2022 through 3/2/2022. The weight documented in vital signs revealed on 3/9/2022, Resident #10 weighed 111.2 pounds (representing an 11.5% weight loss since 1/19/2022) and documented on 3/23/2022 Resident #10 weighed 112.3 pounds. Resident #10 refused to be weighed on 3/16/2022 and 3/30/2022. Attempts were made to interview Nurse #1 who entered the weights for Resident #10 on 3/9/2022 and 3/23/2022, via telephone were unsuccessful. Nurse #1 was assigned Resident #10 on 3/16/2022 and 3/30/2022 when Resident #10 refused to be weighed. Review of Nursing Progress Notes for March 2022 revealed no documentation the physician was notified of Resident #10's weight change or Resident #10's refusals to be weighed. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Physician Progress Notes for March 2022 revealed no physician note that addressed Resident #10's weight loss. Attempts were made to interview the Physician via telephone were unsuccessful. Resident #10 weighed 95 pounds on 4/6/2022, undocumented how the weight was collected. (representing a 24.4% weight loss since 1/19/2022). Review of Nursing Progress Notes for April 2022 revealed no documentation the physician was notified of Resident #10's weight loss. An interview was conducted on 6/8/2022 at 3:11 P.M. with the Unit Manager who entered Resident #10's weight into the electronic medical chart on 4/6/2022. During the interview the Unit Manager revealed when the weights were entered into the computer system, if the weight appeared inaccurate, she requested a reweigh be completed by the assigned nurse. If the reweigh came back with a significant weight change, the physician and the dietician were notified. Resident #10's chart was reviewed with the Unit Manager, the Unit Manager stated, it appeared a reweigh was not completed and the physician was not notified about Resident #10's weight change. Nurse Practitioner Progress note dated 4/7/2022 revealed the reason for the visit with Resident #10 was documented as chronic. The section Assessment and Plan in the progress note indicated Resident #10 had a 16-pound weight loss. The note reads in part Periods of agitation. Requires assistance with ADL's (activities of daily living). Monitor weight. Monitor consumption of meals. Attempts were made to interview Nurse Practitioner via telephone were unsuccessful. An interview was conducted on 6/11/2022 at 8:08 A.M. with Nurse#2. Nurse #2 revealed on 4/7/2022 at the start of her 7 P.M. to 7 A.M. shift, she entered Resident #10's room and told him Hello. She revealed when she spoke to Resident #10, he did not respond to her greeting. Nurse #2 stated this was not normal for Resident #10 and she went to his bedside to assess him. Nurse #2 stated she completed a set of vital signs which were within Resident #10's normal range. During the interview, Nurse #2 stated due to Resident #10's lack of a verbal response, she felt something was wrong. After talking to the physician and Resident #10's responsible party, Resident #10 was sent to the emergency department for evaluation. Resident #10 was admitted to the Hospital on 4/7/2022 with a chief complaint of altered mental status. The physician examination completed in the emergency department on 4/7/2022 at 8:50 P.M. revealed Resident #10 weighed 95 pounds. A nutrition consultation was ordered. Resident #10 was admitted to the hospital on 4/7/2022 with a primary diagnosis of hypernatremia (elevated sodium level). The medical records reviewed showed Resident #10 had a feeding tube inserted through his nose to his stomach (nasogastric tube). On 4/10/2022 an x-ray was ordered and completed for a tube check to verify placement of the nasogastric tube. The x-ray findings revealed a small bowel feeding tube ended in Resident #10's stomach. A review of the hospital course indicated the resident underwent a successful PEG tube placement (feeding tube placed directly into the stomach) on 4/18/2022. The resident was discharged on [DATE] to another skilled nursing facility. Resident #10 had a discharge weight of 104 pounds. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview was conducted on 6/11/2022 at 5:02PM with the Regional Nurse Consultant revealed expectations would be to monitor weights, provide interventions for weight loss and notify responsible parties to include the MD and RP. On 6/12/2022 at 1:55 P.M., the facility's Regional Nurse Consultant and Director of Nursing (DON) were informed of the immediate jeopardy. The facility provided the following acceptable credible allegation of Immediate Jeopardy removal. Credible Allegation of Immediate Jeopardy Removal for F580. 1. Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance: The identified resident (Resident #10) is no longer a resident of the facility. Resident #10 had a 24.4% weight loss from January to April with no notification to Primary Care Provider. The other identified resident (Resident #9) is no longer a resident of the facility. Resident #9 had delay in treatment with failure to notify the physician of results of urinalysis, deterioration of pressure ulcer and continued decline in mental status and condition. All other residents have the potential to be affected by the deficient practice. Other residents were identified as having weight loss. We have had 1 resident refuse weight to be obtained. We will ask them again and will contact family to see if they can assist in encouraging them to be weighed. The Primary Care Provider will be notified by the DON or DON designee within 24 hours for those residents identified to have weight loss. All other residents have the potential to be affected by the deficient practice. Other residents were identified as having skin integrity issues. All resident charts will be audited to determine if any other outstanding labs. have not been addressed, initiating 6/15/2022 and completed by 6/15/2022. The Primary Care Provider will be notified by the DON or DON designee by 6/16/2022 with any identified residents with skin integrity issues that have not been previously identified and any outstanding labs. that have not been addressed. All residents' records were reviewed for change in condition that was not reported/change in wound or pressure sore that was not communicated and completed by 6/16/2022 by the DON and the DON Designee. 100 percent skin body audit of all residents was initiated on 6/14/22 and completed 6/15/2022. Any skin integrity issues identified will be reported to the Primary Care Provider by 6/15/2022. An audit of all residents' charts via Point Click Care system initiated 6/15/2022 conducted by the DON and/or the DON Designee to determine if any labs. have not been addressed and will be completed by 6/15/2022. The Primary Care Provider was notified of all labs. test results. 2. Actions taken to alter the process or system failure to prevent adverse outcome from occurring or recurring: (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Immediate in-service initiated 6/11/2022 and completed on 6/14/2022 for weight loss and immediate in-service initiated 6/14/2022 for observed skin integrity issues with completion on 6/15/2022 and any labs. not being addressed by the Director of Nursing (DON) and/or the Corporate Nurse Consultant to the Licensed nursing staff to ensure that they inform the DON or DON designee of any weight loss initiated 6/11/2022; skin integrity issues; or any labs. that have not been addressed initiated 6/15/2022 with completion of lab. in-servicing 6/16/2022. The in-service will be conducted in person, telephone, or text. Those nurses and nurse aides that will have in-service that was not able to be conducted in person, will be acknowledged on the sign in sheet in-service sheet as to the method of communication conveyed. The staff that received text will have to be provided 1:1 in-service when they report to work prior to caring for resident. Also, signage at the time clock will alert those named that received text to see the DON or DON Designee prior to taking care of the residents. Nursing staff will have evidence of in-service communication initiated by 6/15/2022 and will have the in-person in-service prior to their working shift with signatures on the sign-in sheet prior to them working their shift. The DON and/or DON designee will be responsible for tracking employees who aren't educated and ensuring they are educated prior to them working after 6/17/2022. All newly hired nurses along with any agency staff will receive the information contained in the in-service prior to working with residents. The DON and/or DON Designee initiated in-service on 6/15/2022 with the Licensed nurses and nurse aides to report any changes in a resident's skin integrity, eating habits or any observations that are not typical of the individual resident. Additional in-service training initiated for Nurse Aides on 6/17/2022 regarding any changes in vital signs, any change in habits and routines are to be reported to the nurse. The Nurse Aide should report to the Licensed Nurse and the Licensed Nurse should assess the resident and report and notify the Primary Care Provider of any abnormal findings. Education provided by the DON and/or DON designee and completed by 6/17/2022. The DON and/or DON designee will be responsible for tracking employees who aren't educated and ensuring they are educated prior to them working after 6/17/2022. This education will be given to all newly hired Licensed Nursing staff and agency staff prior to taking their resident assignment. Licensed nursing staff will be educated to notify the Primary Care Provider promptly if they observe a new pressure wound or open area, any signs of wound infection, any wound deterioration. This was initiated on 6/14/2022, by the DON and/or RN certified wound nurse and will be conducted to the nursing staff to include nurses, nurse aides, and agency nursing staff and will be completed by 6/16/2022. This education will be given to all newly hired Licensed Nursing staff and agency staff prior to taking their resident assignment. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility will conduct weekly Focus meetings with the Interdisciplinary team to discuss any resident weight losses, skin integrity issues, and any abnormal labs. or any issues with morning reviews of lab. book to determine if any trends and will discuss the interventions put in place and determine if the interventions are beneficial until the resident meets their or desired body weight; skin assessments, wound measurements with wound healing progress or issues with wound healing; and lab. issues noted in morning reviews by the DON or DON Designee. If interventions are not reflective of achieving desired results, the Primary Care Provider will be notified, and interventions will be re-addressed and potential to add or eliminate and replace interventions as appropriate to achieve weight gain goals; wound healing goals; notification of labs. Completion Date - 6/18/2022 The credible allegation for the immediate jeopardy removal was validated on 6/23/22 with a removal date of 6/18/22. A review of in-service education records from 6/11/22 to 6/17/22 revealed education was provided to nurses and nurse aides on topics that included reporting any weight loss to the nurse and the Unit Manager, reporting any changes in eating pattern and when a resident refused to eat and reporting any changes in the residents' baseline condition such change in vital signs, change in activity, smoking habits and change in daily habits to the nurse. Any new orders, changes in residents' conditions, reports, weight loss, skin integrity issues and laboratory results that have not been addressed need to be communicated timely to the physician, family, and the Director of Nursing. Interviews with the nursing staff revealed they had been educated on when to report a resident's change in condition as well as who to report the change in condition to. They also verbalized the different signs of changes including sepsis and what observations to look for while working with the residents at the facility. The nurses stated they had been educated on notifying the Primary Care Provider of changes such as a new pressure wound or open area, any signs of wound infection and any wound deterioration. This notification to the medical provider also included reporting weight loss and any changes in the residents' condition. The laboratory book was observed at the nurses' station, and it included an audit tool developed by the facility that included information on the resident's name, laboratory test order date, laboratory test ordered, date the results were obtained, any critical laboratory test results and the date and time the medical provider was notified. A weekly focus meeting was held on 6/17/22 which included the Administrator, the Director of Nursing, and the Infection Preventionist. They discussed the following areas: skin observations, wound reports, laboratory audit review/notification, weight loss, change of conditions and acute charting boards.

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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** 43332 Based on record review and staff interviews, the facility failed to obtain a resident's weight within 30 days of the Minimum Data Set (MDS) Assessment Reference Date (ARD, the last day of the look back period) for 1 of 4 MDS assessments reviewed (Resident #10). Findings included: Resident #10 was admitted to the facility on [DATE] with diagnosis of cerebral palsy and seizures. A physician order initiated on 4/21/2021 read in part weekly weights every day shift every Wednesday for weight monitoring. The order was active through the discharge date of [DATE]. Resident #10's weights were observed documented in the electronic medical record (EMR) and reviewed. On 1/19/2022 his weight was noted as 125.7 pounds. There were no further weights documented until 3/09/2022 noted as 111.2 pounds. Both weights had been noted as measured by using the mechanical lift. Resident #10's annual MDS dated [DATE] indicated Resident #10 weighed 126 pounds and had no weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months. An interview with the with the facility's Consultant Registered Dietician (RD) was conducted on 6/13/2022 at 10:28 A.M. The RD stated it was her responsibility to complete the weight section for annual MDS assessments and she used the weight last entered in the EMR. During the interview, the RD reviewed Resident #10's chart. She read the weight on 1/19/2022 as 125.7 pounds and the next weight documented was 3/9/2022 as 111.2 pounds. The RD stated she did not request to have a new weight measured for Resident #10 when she completed Resident #10's annual MDS assessment in March. An interview with the Regional Nurse Consultant was conducted on 6/13/2022 at 12:17 P.M. During the interview the Regional Nurse Consultant stated she would expect the MDS assessment to accurately reflect the resident's weight.

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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** 32394 Based on observations, staff interviews, and medical record reviews, the facility failed to review and revise a resident's care plan to accurately reflect the intervention(s) required for 1 of 2 residents reviewed for an inappropriate resident to resident interaction (Resident #1). The findings included: Resident #1 was admitted to the facility on [DATE] with reentry on 9/29/20 from a hospital. The resident's cumulative diagnoses included non-Alzheimer ' s dementia and bipolar disorder. A review of Resident #1's quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident was assessed to have moderately impaired cognitive skills for daily decision making; no behavioral symptoms were reported. A quarterly MDS assessment dated [DATE] assessed the resident to have intact cognition with other behavioral symptoms not directed towards others occurring on 4 to 6 days, but less than daily during the 7-day look back period. The resident's care plan included an area of focus which addressed his risk for complications related to his diagnoses of dementia and bipolar (initiated 1/10/20) and for having socially inappropriate behavior problems (initiated 4/13/21). On 7/21/21, Resident #1 was reported by staff as having an inappropriate interaction with another resident. The resident was placed on one-on-one care/monitoring at all times. His plan of care was updated on 7/26/21 to include an area of focus regarding this behavior. The interventions included, Will provide one on one care / monitoring at all times (also initiated on 7/26/21). Resident #1's annual MDS assessment dated [DATE] assessed the resident to have moderately impaired cognitive skills for daily decision making; no behavioral symptoms were reported. His Care Area Assessment (CAA) worksheet (dated 8/26/21) related to psychotropic drug use read, .He has presented with behaviors and was recently on one on one for inappropriate behaviors . A review of Resident #1's subsequent MDS assessments included quarterly assessments dated 9/9/21 and 10/1/21. Both assessments reported the resident had moderately impaired cognition with no behavioral symptoms noted. Quarterly MDS assessments dated 1/1/22, 1/22/22, and 4/24/22 indicated Resident #1 had severely impaired cognitive skills for daily decision making; no behavioral symptoms were reported on these assessments. Resident #1's current plan of care continued to indicate one on one care / monitoring at all times was being implemented as an intervention for the resident's inappropriate behavior noted on 7/21/21. This intervention had not been discontinued since it was first initiated on 7/26/21. No revisions had been made to the care plan interventions for this area of focus since 7/26/21. An observation conducted on 6/7/22 at 12:35 PM revealed Resident #1 was sitting in the dining room eating his noon meal. No staff members were in the dining room or within sight of the resident at that time. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 6/11/22 at 8:10 AM with Nurse #2. During the interview, the nurse reported the resident typically stayed near her during the shift and stated, That's his job. She reported inappropriate interactions with other residents had not been a problem as the resident would only go to the doorway of other residents' rooms. The nurse stated she just had to explain it to him. Interviews were conducted with NA #3 And NA #4 on 6/12/22 at 4:50 PM. The NAs both reported they knew Resident #1 well and were assigned to care for him on multiple occasions as part of their assignment (in addition to caring for other residents on his hall). The NAs reported the resident did self-propel his wheelchair and frequently wandered throughout the facility. However, they reported the resident was watched closely and tended to be easily re-directed. An observation was conducted on 6/13/22 at 8:00 AM as Resident #1 was observed to be sitting in his room in a wheelchair while eating his breakfast meal. No staff member was in the room with him or within sight of him at the time of the observation. An interview was conducted on 6/13/22 at 1:17 PM with the Regional Nurse Consultant on 6/13/22 at 1:17 PM. During the interview, the Consultant recalled the incident of 7/21/21 involving Resident #1. She reported the resident was initially placed on one-on-on monitoring 24 (hours) / 7 (days a week) for several weeks. After that, the facility placed him on every 15 minute checks for weeks, then every 30 minute checks for weeks; and finally increased monitoring from staff members. During a follow-up interview conducted with the Regional Nurse Consultant on 6/13/22 at 4:43 PM, the Consultant reported it would have typically been the MDS Nurse ' s responsibility to update the care plan and interventions for Resident #1. She also noted staff nurses had the ability to update a care plan as needed. An interview was conducted on 6/13/22 at 8:07 AM with the facility's interim Administrator in the presence of the new Administrator and Director of Nursing (DON). The interim Administrator reported he worked at the facility at the time of the 7/21/21 incident involving Resident #1 and he recalled both the incident and interventions put into place. When asked if Resident #1 was still on one-on-one monitoring, both the DON and interim Administrator stated, No. A follow-up interview was conducted with the interim Administrator on 6/13/22 at 2:04 PM. During the interview, the Administrator was asked what his expectation was related to Resident #1's care plan. The interim Administrator reported he would have expected the one-on-one monitoring to have been removed from the care plan as soon as it was determined this was no longer necessary.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41069 Based on record reviews, and interviews with staff, family member, Physician Assistant and Medical Director, the facility failed to identify the seriousness of significant changes in a resident's condition (Resident #9), complete and document on-going thorough assessments and identify the need for medical attention when the resident's medical condition continued to deteriorate. This resulted in a delayed treatment for UTI (urinary tract infection) and hospitalization for sepsis due to an infected stage 4 pressure ulcer. This failure was for 1 of 3 residents reviewed for quality of care (Resident #9). Immediate Jeopardy began on 3/26/22 when the facility failed to follow up on Resident #9's urine culture results and provide the care and services required by Resident #9 resulting in a delayed treatment for UTI (urinary tract infection). Resident #9 continued to have confusion, altered mental status, hypotension (low blood pressure) and pressure ulcer deterioration which resulted in Resident #9 being sent out to the emergency room for evaluation and treatment of sepsis due to an infected stage 4 pressure ulcer to the sacrum. Immediate Jeopardy was removed on 6/18/22 when the facility implemented a credible allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity level of E (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to complete employee education and ensure monitoring systems in place are effective. The findings included: Resident #9 was admitted to the facility on [DATE] with diagnoses that included atrial fibrillation, peripheral vascular disease, peripheral artery disease, and hypertension. A physician order dated 10/14/20 in Resident #9's medical record indicated an order for Metoprolol tartrate - give 25 mg (milligrams) by mouth two times a day related to hypertension. Give 3 half tablets if blood pressure is over 140/90. Resident #9's care plan revised on 4/18/21 indicated he had hypertension. Interventions included to give anti-hypertensive medications as ordered, monitor for side effects such as orthostatic hypotension (low blood pressure that happens when standing up from sitting or lying down) and increased heart rate and effectiveness and report significant changes to the physician. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #9 was cognitively intact, had no rejection of care behaviors, required extensive physical assistance with bed mobility, transfer and personal hygiene, and was totally dependent on staff assistance with toilet use. He had impairment to both sides of lower extremities and used a wheelchair. He was always incontinent of both urine and bowel. The MDS further indicated he was at risk of developing pressure ulcers/injuries, but he did not have any unhealed pressure ulcers/injuries. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A progress note written by Nurse #1 on 3/21/22 at 6:18 PM indicated Resident #9 was little bit confused since morning. His vital signs were as follows: blood pressure (BP) at 139/60, pulse at 94, respiratory rate at 20, temperature at 97.9 and oxygen saturation at 97% on room air. Resident #9 denied pain, was diaphoretic and pale. Blood glucose was 225 mg/dL (milligrams per deciliter). He was refusing to go back to bed. He refused lunch and went out for smoke. BP was rechecked at 130/80 manually and pulse at 88. Nurse Practitioner (NP) was informed and ordered the following: CBC (complete blood count), CMP (comprehensive metabolic panel), CXR (chest x-ray) and UA (urinalysis). Resident #9 ate 40% of his supper. Resident #9's family member was notified regarding his present condition. A phone interview with Nurse #1 on 6/12/22 at 6:43 PM revealed she noticed Resident #9 had a decline on 3/21/22 because he was not eating and had to be assisted to eat. He was also diaphoretic, pale and had been having episodes of confusion which was not normal for him. Resident #9 was usually alert and oriented. Nurse #1 informed the NP who ordered bloodwork, chest x-ray and urinalysis with urine culture. Nurse #1 stated she obtained the urine specimen through straight catheterization and sent it to the laboratory on 3/21/22. Nurse #1 stated she noticed that Resident #9's urine was very concentrated when she obtained his urine sample, so she obtained an order for an indwelling catheter because she had a hard time getting a urine sample from him and she thought he might have urinary retention. Nurse #1 stated she had suspected that Resident #9 might have a urinary tract infection given the new onset of confusion. A physician progress note dated 3/22/22 indicated Resident #9 was seen by the Medical Director and he noted Resident #9 was afebrile and more alert per nurse. He appeared to not feel well but no acute distress noted. Resident #9 ate breakfast and was drinking some but blood pressure low for him this morning (110/64). Metoprolol was held. Resident #9's blood pressure normally ranged between 110/60 and 140/80. Skin tenting (skin abnormality indicative of dehydration) was present. Intravenous fluids ordered. A review of the Physician Orders dated 3/22/22 in Resident #9's medical record indicated the following: *Dextrose-Sodium Chloride Solution 5-0.9% - use 75 ml (milliliters)/hour for 2 days x 3 liters for dehydration. *Insert an indwelling catheter and connect to urine bag for urinary retention. Further review of Resident #9's medical record indicated a faxed result from the laboratory dated 3/23/22 at 8:46 PM for a urinalysis with the following abnormal values: cloudy appearance, leukocytes 3+, protein 100, blood 3+, WBC (white blood cells) 3+ and bacteria 3+. A urine culture result reported by the laboratory on 3/26/22 at 11:22 AM indicated Resident #9's urine had a growth of Providencia stuartii of >100,000 cfu (colony-forming unit)/ml (milliliter). The report also outlined the different antibiotics that the organism was susceptible and resistant to. A review of Resident #9's medical record indicated no evidence that the urinalysis and urine culture results received on 3/26/22 were reported to the Nurse Practitioner or to the Medical Director. Resident #9's Vital Signs Record from 3/21/22 to 4/5/22 indicated his temperature and pulse were not checked on 3/26/22, 3/27/22, 3/28/22, 3/29/22, 3/30/22, 4/1/22, 4/2/22, 4/4/22 and 4/5/22. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The progress notes and the Medication Administration Record in Resident #9's medical record indicated his Metoprolol dose was held on the following dates and times because his blood pressure was less than 140/90: 3/22/22 at 8:44 AM (BP-110/64), 3/23/22 at 8:54 AM (BP-109/54), 3/23/22 at 9:19 PM (BP-116/57), 3/24/22 at 9:44 PM (BP-105/43), 3/25/22 at 8:40 PM (BP-118/52), 3/30/22 at 8:38 PM (BP-96/50), 3/31/22 at 10:16 PM (BP-98/48) and 4/1/22 at 8:17 AM (BP-98/48). A phone interview with Nurse #2 on 6/13/22 at 2:12 PM revealed she had taken care of Resident #9 on the evening shift when he started to get sick on 3/21/22. Nurse #2 stated she noticed a change in his condition when he called her by another nurses' name, and he was getting more confused. She remembered him receiving intravenous fluids, but she had to hold his blood pressure medication on 3/22/22, 3/23/22, 3/24/22, 3/25/22 and 3/31/22 because his blood pressure was low. Nurse #2 stated at first the low blood pressure reading didn't alert her because Resident #9's blood pressure fluctuated all the time. Nurse #2 also stated she had thought about Resident #9 possibly having sepsis, but she assumed he was being seen by the wound doctor for his pressure ulcer on his sacrum. Nurse #2 further stated she worked on 3/23/22 but didn't remember seeing Resident #9's urinalysis result and was not aware that he had UTI. She couldn't remember if it was passed on during report that they were still waiting on Resident #9's urinalysis and urine culture results. Nurse #2 also stated she had done most of Resident #9's hydrocolloid dressing in March 2022 and she noticed that the open wound on his buttocks had gotten worse, but she didn't remember exactly when it started to get worse. Nurse #2 stated she remembered Resident #9's wound being slightly smaller than the size of a quarter when she started working with him but on 3/30/22 when she had changed his hydrocolloid dressing, she noticed that the wound had gotten bigger to the size of a baseball, and it was draining more. Nurse #2 did not notify the doctor of the worsening of Resident #9's pressure ulcer because she thought he was already being seen by the wound doctor. A phone interview with Nurse #7 on 6/13/22 at 12:18 PM revealed she took care of Resident #9 on 3/24/22 and 3/25/22 and had to change his hydrocolloid dressing on both days. Nurse #7 stated she first saw Resident #9's ulcer to his sacrum on 3/24/22. Nurse #7 stated she observed a quarter-sized open area on Resident #9's bottom that looked clean, pink and had no drainage and no foul odor. Nurse #7 did not report this observation to anyone as she thought this was normal for him. She also did not remember receiving on report that they were waiting on Resident #9's urinalysis and urine culture results. A phone interview with Nurse #5 on 6/13/22 at 11:06 AM revealed she worked with Resident #9 on the evening shift on 3/26/22 but she never received a report that they were waiting on Resident #9's urinalysis and urine culture results. She did not see Resident #9's urine culture result on the fax machine. Nurse #5 stated she also took care of Resident #9 on 3/27/22 and 3/28/22 and had only checked his blood pressure on those dates to determine if she could give his Metoprolol dose. She did not check his temperature and was not aware that he had a UTI at that time. A progress note written by the Interim Director of Nursing (DON) on 3/30/22 at 1:00 PM indicated she called Resident #9's family member for an update and informed him that Resident #9 was confused again today and had pulled his midline (intravenous catheter) out last night on third shift. Resident #9 appeared to be delirious as confusion comes and goes. Urinalysis came back indicating UTI with >100,000 Providencia stuartii. The Interim DON notified the Nurse Practitioner through electronic message and an antibiotic was requested. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview with the Interim DON (DON through 6/6/22) on 6/13/22 at 10:43 PM revealed Resident #9 had intermittent confusion within the last 4-6 weeks when he was at the facility, but she noticed that Resident #9 was a lot more confused on 3/30/22. She stated Resident #9 was talking out of his head and he was still in bed late that morning when he would usually be up before the first morning smoking time at 8:00 AM. The Interim DON remembered the Nurse Practitioner (NP) saying that Resident #9 was dehydrated which was why he was receiving intravenous fluids. She stated she looked through Resident #9's medical record on 3/30/22 and discovered a urine culture report dated 3/26/22 that hadn't been addressed. She reported this to the NP and requested an order for an antibiotic for the UTI. The Interim DON stated on the day the laboratory reported results to them, they would receive an alert directly in the electronic medical record to notify them of any new result. However, if a staff member opened up the alert, it would clear out, but that wouldn't necessarily mean that someone had followed up on it. The Interim DON also stated she was not sure if she had received a report from the nurse before her that they were waiting on Resident #9's urinalysis and urine culture results. A phone interview with Nurse #8 on 6/14/22 at 11:03 AM revealed she took care of Resident #9 on the night shift from 7:00 PM on 3/30/22 to 7:00 AM on 3/31/22. Nurse #8 gave Resident #9's first dose of antibiotic injection intramuscularly because he had pulled off his midline catheter. Nurse #8 thought they were still waiting on his urine culture results and was not aware that it had been reported by the laboratory on 3/26/22. Nurse #8 stated things often got trickled down during report between the nurses and not everything got followed up on. She also did not check his temperature and pulse but had noted that his blood pressure was low, so she held his Metoprolol dose for 8:00 PM. Nurse #8 stated she put a note in the provider's notebook about Resident #9's blood pressure so they could see it when they come the next day. Nurse #8 stated she didn't think it was something she had to report right then and didn't use the electronic message through the tablet to communicate with a provider. A physician order dated 3/31/22 in Resident #9's medical record indicated an order for Cetriaxone Sodium Solution Reconstituted - use 2 grams intravenously every 24 hours for UTI for 7 days, in 2 gram/50 ml (milliliters) in dextrose. Ceftriaxone is a cephalosporin antibiotic used to treat a wide variety of bacterial infections. It works by killing bacteria or preventing their growth. A Nurse Practitioner note dated 3/31/22 of Resident #9's general medical condition indicated he was being treated for UTI. There was no assessment or mention of the buttocks wound. Multiple attempts were made to contact the NP, but they were unsuccessful. The NP no longer worked with the Medical Director's team. An interview with Nurse #4 on 6/13/22 at 4:01 PM revealed she took care of Resident #9 on 4/1/22 and had to hold his 8:00 AM Metoprolol dose because his blood pressure was low. She didn't check the rest of his vital signs including his temperature and pulse because it wasn't indicated on the Medication Administration Record. Nurse #4 stated Resident #9's low blood pressure didn't alert her because she thought he was receiving intravenous fluids because his blood pressure had been low. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A phone interview with Nurse #3 on 6/13/22 at 10:20 AM revealed she took care of Resident #9 from 7:00 AM to 7:00 PM on 4/2/22 and 4/3/22. Nurse #3 recalled seeing the wound on his buttocks on 4/3/22 when she had to change the hydrocolloid dressing. Nurse #3 stated she was surprised to see how bad the wound looked and stated it was the worst-looking pressure ulcer she had ever seen. Nurse #3 described the ulcer as unstageable and reported that it was black and red in some areas and had a foul odor. After Nurse #3 saw the wound, she called the former Director of Nursing (DON) into the room and the former DON placed an antiseptic dressing on the wound. Nurse #3 assumed that the former DON had notified the doctor of Resident #9's pressure ulcer and received an order for the antiseptic dressing. Nurse #3 stated she did not notify the doctor of the pressure ulcer because she had let the former DON know and she thought she was going to take care of it. A phone interview was attempted on 6/13/22 at 12:01 PM, 6/14/22 at 12:00 PM and 6/15/22 at 10:19 AM with the former DON with no return call. A phone interview with Resident #9's family member on 6/7/22 at 12:15 PM revealed he visited Resident #9 at the facility and often talked to him by phone. When he visited Resident #9 on 4/1/22, he noticed Resident #9 was out of it and then on 4/5/22, he didn't even recognize him. Resident #9's family member stated he was concerned that Resident #9 had developed a UTI, so he asked the staff to go ahead and send him to the hospital. At the ER (emergency room), Resident #9 had a wound on his buttocks that was black and smelled of dead tissue. A follow-up interview with the Interim Director of Nursing (DON) on 6/13/22 at 3:00 PM revealed the nursing staff were only supposed to communicate with the providers through text messages through the tablet and the facility did not utilize a notebook for the providers. The Interim DON stated she did not see any documentation/communication regarding Resident #9's worsening condition from 3/22/22 to 4/5/22 except when she had notified the NP of his urine culture results on 3/30/22. The Interim DON also stated that she checked the nurse to physician documented communication text messages and there was no report to the medical staff that Resident #9's wound to his buttocks had opened, was large and black. An interview on 6/14/22 at 12:25 PM with the Physician Assistant (PA) currently working at the facility revealed the provider should have been keeping an eye out for laboratory results that they had ordered. Whenever laboratory results were ready, they automatically populated in the electronic medical record and the NP who had ordered Resident #9's urinalysis and urine culture should have followed up when it became available. The PA stated she would have expected the nurses to monitor Resident #9's vital signs because the blood pressure would typically go down as the infection worsened because of the fluids trying to get into the tissues to fight the infection. A phone interview with the Medical Director (MD) on 6/14/22 at 4:22 PM revealed he was familiar with Resident #9 and remembered him having a routine work-up for altered mental status which included CBC. CMP, CXR and UA. The MD stated he didn't know that there was delay with starting Resident #9 on antibiotics for UTI, but he would have hoped the nursing staff had followed up on the urine culture result, so it was communicated to the NP who had ordered the urinalysis and urine culture. The MD stated he also expected the nurses to have assessed Resident #9 who was acutely ill and checked his vital signs at least once a day. He also expected the nursing staff to report any decline in condition especially the deterioration of Resident #9's pressure ulcer and continued low blood pressure readings even though he was receiving intravenous fluids. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #9's hospital admission notes dated 4/5/22 indicated Resident #9 was seen in the Emergency Department for altered mental status. Resident #9 was found to have severe sepsis/septic shock with acute organ dysfunction, an infected decubitus ulcer stage IV, a pressure injury of buttock stage IV, elevated white blood cells indicating an infection, metabolic encephalopathy, acute renal failure superimposed on chronic kidney disease stage 3, intravascular volume depletion (dehydration), and low sodium. The surgical consult for decubitus sacral ulcer determined the ulcer was large, necrotic, and malodorous ulcer with only minimal erythema. Plan was for surgical debridement and diverting colostomy. It was suspected the sacral ulcer was contaminated with stool. Resident #9 was critically ill and at risk for decompensation resulting in end-organ dysfunction. The resident's fevers were up to 103 Fahrenheit due to an infected sacral pressure ulcer. A CT (computed tomography) scan of the sacral pressure ulcer revealed extensive subcutaneous gas formation (deep seeded infection with gas forming organisms) and tunneling upward within the gluteal and above the gluteal tissues. Resident #9 also had a stage 4 pressure ulcer to the right plantar foot and a soft tissue ulcer to the great toe stump. An interview with the Director of Nursing (DON) on 6/15/22 at 1:40 PM revealed she expected the nurses to follow up on laboratory results and address them with the doctor. While waiting on results from the laboratory, this information should be reported by the nurses to each other, so they knew to monitor for the laboratory result. The DON stated she expected the nurses to monitor acutely ill residents by obtaining a full set of vital signs at least once during their shift and to call the doctor about any acute issues or change in condition. The Administrator was notified of Immediate Jeopardy on 6/15/22 at 1:41 PM. The facility provided the following IJ Removal Plan with the correction date of 6/18/22. 1. Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance: The identified resident (Resident #9) is no longer a resident of the facility. The facility failed to complete thorough and ongoing assessment of a resident after a significant change in condition and failed to report urinalysis results and deterioration of pressure ulcer to the Primary Care Provider. All other residents have the potential to be affected by the deficient practice. All resident charts were audited to determine if any other outstanding labs. have not been addressed, initiated on 6/15/2022 and completed on 6/15/2022. The Primary Care Provider was notified by the Director of Nursing (DON) or DON designee on 6/15/2022 with any identified residents with skin integrity issues that have not been previously identified. The Primary Care Provider will be notified by the DON or DON designee by 6/16/2022 with any identified residents with any outstanding labs. that have not been addressed. Licensed Nurses and Nurse Aides interviewed to determine if any current residents have had any significant changes of their conditions, if so DON and/or the DON designee will assess the resident to determine if a significant change has occurred and will notify the Primary Care Provider of change by 6/16/2022. An audit of all residents' charts via Point Click Care system was completed on 6/15/2022 by the DON and/or DON designee to determine if any labs. have not been addressed. 2. Actions taken to alter the process or system failure to prevent adverse outcome from occurring or recurring: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Immediate in-service initiated 6/15/2022 for observed skin integrity issues and any labs not being addressed by the DON and/or the DON Designee to the Licensed nursing staff, Nurse Aides, and any agency staff regarding assessing residents with any change in condition and to report any deterioration of pressure ulcer to the Primary Care Provider immediately. The DON and/or DON Designee initiated in-service on 6/15/2022 with the Licensed nurses and nurse aides to report any changes in a resident's skin integrity, eating habits, altered mental status or any observations that are not typical of the individual resident. The Nurse aide should report to the Licensed Nurse and the Licensed Nurse should assess the resident and report and notify the Primary Care Provider of any abnormal findings. * Licensed nursing staff will be educated to notify the Primary Care Provider promptly if they observe a new pressure wound or open area, any signs of wound infection, any wound deterioration. This was initiated on 6/14/2022, by the DON and/or RN certified wound nurse will be conducted to the nursing staff to include nurses, nurse aides, and agency nursing staff and will be completed by 6/16/2022. The DON and/or DON designee will be responsible for tracking employees who aren't educated and ensuring they are educated prior to them working after 6/16/2022. This education will be given to all newly hired Licensed Nursing staff and agency staff prior to taking their resident assignment. * Licensed Nursing staff to included agency will be educated to notify the Primary Care Provider if a newly admitted resident is noted to have open wound/pressure sore. Any new resident with wound or open area will have orders to conduct weekly skin assessments and measurements on TAR. This education was initiated on 6/14/2022, by DON and/or RN certified wound nurse and will be completed by 6/16/2022. This education will be given to all newly hired Licensed Nursing staff and agency staff prior to taking their resident assignment. * Licensed Nursing staff to include agency will be educated on signs and symptoms of sepsis to include: faster heart rate, reduced urine output, fever and chills, difficulty breathing, mental confusion and hyperventilation. This education was initiated on 6/14/2022, by DON and/or RN certified wound nurse and will be completed by 6/16/2022. The DON and/or DON designee will be responsible for tracking employees who aren't educated and ensuring they are educated prior to them working after 6/16/2022. This education will be given to all newly hired Licensed Nursing staff and agency staff prior to taking their resident assignment. * The Nurse aides will be educated to notify the nurse with any changes in skin integrity immediately to the individual resident's nurse. Such changes as redness, rashes, any skin break, abrasions, or any unusual skin integrity observations that were not noted with skin observation during prior care provided. Nurse Aides will also be educated on signs and symptoms of sepsis to include: faster heart rate, reduced urine output, fever and chills, difficulty breathing, mental confusion and hyperventilation. This education was initiated on 6/14/2022, by DON and/or RN certified wound nurse and will completed by 6/16/2022. The DON and/or DON designee will be responsible for tracking employees who aren't educated and ensuring they are educated prior to them working after 6/16/2022. This education will be given to all newly hired Licensed Nursing staff and agency staff prior to taking their resident assignment. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	* Facility will implement Acute Charting Board that will be placed on each Medication cart for each Licensed Nurse to review and chart on each shift. Acute Charting Board will include any resident who is having an acute episode or event to alert the Licensed Nurse to chart a thorough assessment depending on the condition of the resident every shift i.e.: new onset antibiotic, fall with or without injuries, any new or worsening behaviors, altered mental status, change of condition, IV fluids. The Acute Charting Board will be updated by the Licensed Nurse taking care of the resident that has the acute change or event and the DON and/or Designee will ensure updates are addressed based on the 24-hour report and/or clinical meeting. This will be implemented on 6/16/2022. The Licensed Nurse will have to chart every shift their assessment until the Resident is stable and the Resident can only be removed from the Acute charting book by the Weekend Supervisor/DON and/or the DON Designee when the resident is no longer in need of acute charting. The residents in the acute charting will have a list of resident names on a list so the nurses will know who to chart on. The acute charting and any assessments or changes during the shift will be communicated with the oncoming shift. In-service education will be initiated on 6/16/2022 by DON and/or DON Designee and completed by 6/16/2022. The DON and/or DON designee will be responsible for tracking employees who aren't educated and ensuring they are educated prior to them working after 6/16/2022. This education will be given to all newly hired Licensed Nursing staff and agency staff prior to taking their resident assignment. * In-service education was initiated on 6/16/2022 by DON and/or DON Designee and completed by 6/16/2022. A thorough assessment includes aspects related to the individual resident's needs and monitoring. For example, the licensed nurses were in-serviced to monitor for signs and symptoms of Sepsis and to notify the Primary Care Provider if the resident exhibits any signs or symptoms of Sepsis. The licensed nurses were in-serviced on weight monitoring and if any weight loss greater than 5 pounds from previous weight, there will be notification of Primary Care Provider and RD. The licensed nurses were in-serviced on any resident with fall to determine if any injury and to send out to hospital if any change in resident cognitive status or complaints of pain or obvious injury as laceration requiring sutures, any pupillary changes, also observation for 72 hours after fall unwitnessed if no serious injury note with; the licensed nurses were in-serviced to notify if any change in the resident from their normal cognitive behavior baseline or typical habits, routines or any changes in food intake. The licensed nurses were in-serviced as to any change in vital signs such as increase or decrease in temperature, heart rate, blood pressure and respirations and any symptoms that are exhibited with change of vital signs to notify the Primary Care Provider. The licensed nurses were in-serviced as to any changes in wound size, changes in color, drainage, odor, or pain to be reported to the Primary Care Provider. Any resident on IV fluids will have vital signs taken every shift while on IV therapy. The DON and/or DON designee will be responsible for tracking employees who aren't educated and ensuring they are educated prior to them working after 6/17/2022. This education will be given to all newly hired Licensed Nursing staff and agency staff prior to taking their resident assignment. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Facility will implement and keep at the nurses' station Interact Care Path Tools Workbook/SBARs (Situation, Background, Assessment, Recommendation). An education Tool and Reference for Guiding Evaluation of Specific Symptoms That Commonly Cause Acute Care Transfer. This tool guide provides clear instructions on what signs and symptoms needs to be reported immediately to the Primary Care Provider, what can wait until the following day and when a resident needs to be assessed by a Medical Provider, this will be implemented on 6/16/2022. In-service education will be initiated on 6/16/2022 by the DON and/or DON designee and completed by 6/17/2022. The DON and/or DON designee will be responsible for tracking employees who aren't educated and ensuring they are educated prior to them working after 6/16/2022. This education will be given to all newly Licensed Nurses and agency licensed nurses prior to taking their resident assignment. This education was provided to licensed nurses on 6/16/22 and 6/17/22. * The DON and/or DON designee will review all change of conditions in clinical meeting to ensure SBARs were completed along with Primary Care Physician and family notification (if they are responsible party). If the DON and/or DON designee find any issues, the DON or DON Designee will notify the Primary Care Provider. Clinical meetings will be held every weekday morning after the morning stand up meetings. The weekend RN or DON Designee will review the 24-hour report and will ensure any changes in the resident condition is addressed and proper notification to the Primary Care Provider and the responsible party. The needed documentation for the 24-hour report was included in the in-service training. * Lab. book will be implemented and kept at the nurses' station that will reflect ordered labs. and notification of Primary Care Provider when lab. results have been obtained. The book will reflect the resident's name, the date of the lab. ordered, the ordered lab., the date results obtained and if critical labs. noted, the notification date and time the Primary Care Provider was notified. The Nurse receiving lab. order will place lab. in the lab. book. The Nurse who receives lab. results will notify Primary Care Provider of any Critical Lab. results and document in the lab. book of doing notification. All critical labs. are called to the Nurse at the facility from the Lab. In-service education will be initiated on 6/16/2022 by DON and/or DON Designee and completed by 6/17/2022. The DON and/or DON designee will be responsible for tracking employees who aren't educated and ensuring they are educated prior to them working after 6/17/2022. This education will be given to all newly hired Licensed Nursing and agency staff prior to taking their resident assignment. * The DON and/or Designee will review the lab. book every morning to determine if any labs. have not been addressed and/or Primary Care Provider notified. The DON and/or Weekend supervisor will check the lab. book on the weekend to ensure the same. If the DON and/or DON Designee find any issues, the DON or DON Designee will notify the Primary Care Provider. The weekend supervisor was educated 6/16/2022 and has been informed of her responsibility in this regard. The in-service will be conducted in person, telephone, or text. Those Nurses and Nurse aides that have in-service that was not able to be conducted in person, will be acknowledged on the sign in in-service sheet as to the method of communication conveyed. The staff that received text will be provided 1:1 in-service when they report to work prior to caring for residents. Also, signage at the time clock will alert those [TRUNCATED]

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41069 Based on observations, record reviews, and interviews with staff, Wound Physician, Physician Assistant, and Medical Director, the facility failed to complete skin assessments as ordered, effectively assess, and monitor a pressure ulcer, and ensure treatments/interventions were implemented and modified/adjusted according to resident's response (Resident #9). Resident #9 who was at high risk for pressure ulcers was hospitalized on [DATE] with an infected stage 4 pressure ulcer (full-thickness skin and tissue loss) with tunneling (passageway of tissue destruction under the skin surface). In addition, the facility failed to update physician orders on a resident's Treatment Administration Record (TAR) to match the wound dressing orders in the Wound Physician notes for wound dressings (Resident #6). These failures were for 2 or 3 residents reviewed for pressure ulcers (Resident #9 and Resident #6). Immediate jeopardy began on [DATE] when the facility failed to provide the necessary care and services for a pressure ulcer that deteriorated in condition. The facility failed to modify the treatment, implement interventions, monitor/evaluate the impact of the interventions, and adjust accordingly. This led to a high-risk resident (Resident #9) being hospitalized on [DATE] for sepsis due to an infected stage 4 sacral pressure ulcer. On [DATE], Resident #9's family decided on comfort-guided care with hospice. Resident #9 was transferred to the hospice house on [DATE] and died on [DATE] due to cerebral infarction. The Immediate Jeopardy was removed on [DATE] when the facility implemented an acceptable credible allegation for Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity level of E (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure education and monitoring systems put into place are effective. Example #2 was cited at a scope and severity level of E. The findings included: 1. Resident #9 was admitted to the facility on [DATE] with diagnoses that included hypertension, atrial fibrillation, peripheral vascular disease, peripheral artery disease, obesity, nicotine dependence, paraplegia and wheelchair bound since 2012. A review of the Physician's Orders in Resident #9's medical record indicated an order for the following: [DATE] - Weekly skin check/skin observation tool every Wednesday and Saturday on the evening shift. [DATE] - Mix Zinc Oxide diaper relief cream with (brand name) moisture barrier ointment and apply to excoriation on buttocks, groin, and upper posterior thighs twice a day and as needed. Resident #9's care plan initiated on [DATE] indicated Resident #9 had a pressure area to the left ischium (curved bone forming the base of each half of the pelvis). He refused to be put back to bed due to him being a smoker and he only wanted to lie down once a day for incontinence care and then wanted right back up to smoke. He refused to see the wound doctor. Interventions included to administer treatments as ordered and monitor for effectiveness, encourage the resident to lie down during the day, if the resident refuses treatment, confer with the resident, interdisciplinary team, and family to determine why and try alternative methods to gain compliance and document alternative methods. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The last Wound Evaluation and Management Summary completed by the wound physician on [DATE] indicated Resident #9 had a shear, full thickness wound to the left buttock which measured 3.2 cm (centimeters) in length, 1.3 cm in width and 0.1 cm in depth. He also had a shear, full thickness wound to the right buttock which measured 1.2 cm in length, 2 cm in width and 0.1 cm in depth. Both wounds had a light serous exudate. The wound physician applied a hydrocolloid dressing to each buttock. A phone interview with the Wound Physician on [DATE] at 11:30 AM revealed he had not seen Resident #9 for the past 6 months because Resident #9 had declined assessment at times. There was also no family involvement or team meeting to address non-compliance and Resident #9 was discharged from his service on [DATE] after his last visit. The facility had not informed him that Resident #9 had required his services due to his recent decline. A physician order dated [DATE] indicated an order for hydrocolloid dressing every Monday, Wednesday, and Friday on night shift to the right and left buttocks (shear/open areas). The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #9 was cognitively intact, had no rejection of care behaviors, required extensive physical assistance with bed mobility and personal hygiene, and was totally dependent on staff assistance with toilet use and bathing. He had impairment to both sides of his lower extremities and used a wheelchair. The MDS further indicated Resident #9 was always incontinent of both urine and bowel. Resident #9 was at risk of developing pressure ulcers/injuries, but he didn't have any unhealed pressure ulcers/injuries. He had a pressure reducing device for bed and received application of ointments/medications. A document entitled, Braden Scale for Predicting Pressure Ulcer Risk, dated [DATE] indicated Resident #9 was at high risk for developing a pressure ulcer due to very limited sensory perception, very moist skin, chairfast and very limited mobility. He also had a problem with friction and shear due to him requiring moderate to maximum assistance in moving and complete lifting without sliding against sheets was impossible. The most recent weekly skin check/skin observation tools in Resident #9's medical record were documented by Nurse #1 on [DATE] and [DATE]. On [DATE], Nurse #1 documented Resident #9 had redness to his buttocks and groin area. On [DATE], Nurse #1 documented Resident #9 had a rash to his bottom. Resident #9's care plan last revised on [DATE] indicated Resident #9 had a pressure ulcer to the coccyx. He had been in bed due to decline and refused to be turned off his back. Interventions included to administer treatments as ordered and monitor for effectiveness. If the resident refused treatment, confer with the resident, interdisciplinary team, and family to determine why, and try alternative methods to gain compliance and document alternative methods. A review of Resident #9's medical record indicated there was no evidence of any other weekly skin check/skin observation tool completed after [DATE]. The progress notes from [DATE] to [DATE] indicated no documented refusal from Resident #9 with wound care/treatment, skin checks and wound assessments. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A phone interview with Nurse #1 on [DATE] at 6:43 PM revealed she completed a skin check on Resident #9 on [DATE] and observed no open areas on his buttocks. Nurse #1 stated Resident #9's bottom had always been red, but she did not note any open wound or ulcer. She applied barrier cream to his buttocks as ordered. Nurse #1 stated she couldn't remember if Resident #9's buttocks had a hydrocolloid dressing on when she did his skin check. On [DATE], Nurse #1 completed another skin check on Resident #9 and she observed rashes to his bottom, so she applied his prescribed barrier cream. Nurse #1 further stated she also couldn't remember if there was a hydrocolloid dressing on Resident #9's buttocks when she checked his skin on [DATE]. A phone interview with Nurse #5 on [DATE] at 11:06 AM revealed she was assigned to complete a skin check on [DATE] on Resident #9 but she couldn't remember what his skin looked like that day, and she failed to completely document his skin evaluation because of interruption during the shift. Further interview with Nurse #5 revealed she took care of Resident #9 on [DATE] and she noted a tremendous change on Resident #9's buttocks when she was about to change his hydrocolloid dressing on [DATE]. Nurse #5 stated she observed an open decubitus ulcer which measured approximately 8 cm in length and 8 cm in width with a ,d+[DATE] cm depth. The ulcer had a lot of drainage, and she noticed a foul odor, but she wasn't sure if all the odors came from the wound because she had to clean up urine and stool that had contaminated the wound. Nurse #5 said feces would often get on Resident #9's dressing and she had to change it a few times on her shift. Nurse #5 stated she was shocked at how much Resident #9's pressure ulcer had deteriorated, and she knew he needed to be referred to a wound doctor or the facility physician but didn't think he needed to be sent out to the hospital at that time. When the former Director of Nursing (DON) came in the next day to relieve Nurse #5 from the medication cart, Nurse #5 recalled telling the former DON that Resident #9 needed to see the wound doctor. The former DON assured her she would look at the wound and do whatever was necessary. A phone interview with Nurse #7 on [DATE] at 12:18 PM revealed she took care of Resident #9 on [DATE] and [DATE] and had to change his hydrocolloid dressing on both days. Nurse #7 stated she first saw Resident #9's ulcer to his sacrum on [DATE]. Nurse #7 stated she observed a quarter-sized open area on Resident #9's bottom that looked clean, pink and had no drainage and no foul odor. Nurse #7 did not report this observation to anyone as she thought this was normal for him. She also did not complete a wound assessment because she didn't think she had to. An interview with Nurse Aide (NA) #4 on [DATE] at 4:38 PM revealed she worked on the evening shift and often provided a bed bath to Resident #9. NA #1 stated when she started working with Resident #9 in [DATE], he only required one dressing to each buttock. But when she gave him a bed bath on [DATE], NA #4 observed a big wound on his bottom which smelled bad. NA #4 stated she was horrified at the sight of Resident #9's pressure ulcer that she didn't want to remember or even think about what it looked like. NA #4 stated she informed Nurse #8 who ended up placing at least 4 dressings to Resident #9's pressure ulcer. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A phone interview with Nurse #8 on [DATE] at 11:03 AM revealed she had to change Resident #9's hydrocolloid dressing on [DATE] and he had several scattered open areas that were irregularly shaped on his buttocks and ischial (lower part of the hip bone) areas. Nurse #8 remembered having to apply 4 hydrocolloid dressings with one on each buttock and one on each ischial area. Nurse #8 described the wounds as red and beefy, and she recalled that she didn't have to pack any of the wounds. They drained a lot and had some odor, but she didn't think she had to report it to the doctor or complete a wound assessment. Nurse #8 couldn't give approximate measurements of the wounds but stated that the ulcer on the right buttock was smaller than the one on the left. She wasn't sure about the odor as well because they had to clean up Resident #9 and remove urine and stool off the wound. Nurse #8 stated the area where his ulcers were located were easily contaminated with stool and urine. Nurse #8 also stated that NA #4 probably thought the wounds looked bad because they were bleeding and had a lot more drainage than usual. A phone interview with Nurse #2 on [DATE] at 2:12 PM revealed she had done most of Resident #9's hydrocolloid dressing in [DATE] and she noticed that the open wound on his buttocks had gotten worse, but she didn't remember exactly when it started to get worse. Nurse #2 stated she remembered Resident #9's wound being slightly smaller than the size of a quarter when she started working with him but on [DATE] when she had changed his hydrocolloid dressing, she noticed that the wound had gotten bigger to the size of a baseball, and it was draining more. Nurse #2 did not notify the doctor of the worsening of Resident #9's pressure ulcer because she thought he was already being seen by the wound doctor. Nurse #2 also stated she didn't think about completing a wound assessment and didn't think his wound was that severe that she needed to send him to the hospital at that time. A physician order dated [DATE] in Resident #9's medical record indicated an order for Ceftriaxone Sodium solution - inject 1 gram intramuscularly for UTI (urinary tract infection) x 2 doses in separate sites. Ceftriaxone is a cephalosporin antibiotic used to treat a wide variety of bacterial infections. It works by killing bacteria or preventing their growth. An interview with the Unit Manager (UM) on [DATE] at 9:20 AM revealed she injected a prescribed antibiotic into Resident #9's buttock on [DATE] but could not recall whether or not Resident #9 had a dressing that covered his coccyx or buttocks at the time of the injection. The UM stated that she was focused on giving Resident #9 the shot that she didn't notice any abnormalities or open areas to his buttocks. She reported there was nothing that alarmed her or caused any concern, and she did not notice any odor. An interview with Nurse #9 on [DATE] at 11:05 AM revealed she was not usually assigned to take care of Resident #9 but had changed his wound dressing before whenever he complained to her that he was having a hard time getting the nurses to change his dressings. Nurse #9 stated she went ahead and did his dressing, but she couldn't remember what his buttocks looked like at that time. Nurse #9 stated this happened in [DATE] and had reported this to the former DON. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A phone interview with NA #5 on [DATE] at 8:40 AM revealed she worked with Resident #9 from 7:00 PM to 7:00 AM and he was usually already in the bed whenever she came in to work. Resident #9 knew whenever he needed to have his brief changed and he used his call light whenever he needed something. NA #5 stated he was always compliant with her, and he always let her provide incontinence care to him. NA #5 stated Resident #9's bottom always had small, slashed areas whenever she started working with him. NA #5 noticed Resident #9's bottom starting to break down and that was when they started putting a dressing to the open areas and they would usually put one dressing to each buttock. She couldn't tell for sure when Resident #9's buttocks started to worsen but she said it had been open for at least a month before he was sent to the hospital. NA #5 stated the drainage from the wound increased and she noticed a foul odor coming from it. She remembered one time when his dressing had come off, she told Nurse #7 about it, and she was told by Nurse #7 that he would have to wait because the dressing change was not scheduled to be done on her shift. NA #5 could not remember when this had happened. A progress note dated [DATE] and written by Nurse #3 indicated Resident #9 had a huge unstageable ulcer on the buttocks. Ulcer was very large, approximately 8 centimeters (cm) by 8 cm unstageable. Cleaned ulcer on coccyx with wound cleanser and (antiseptic) dressing applied. A phone interview with Nurse #3 on [DATE] at 10:20 AM revealed she took care of Resident #9 from 7:00 AM to 7:00 PM on [DATE] and [DATE]. Nurse #3 recalled seeing the wound on his buttocks on [DATE] when she had to change the hydrocolloid dressing. Nurse #3 stated she was surprised to see how bad the wound looked and stated it was the worst-looking pressure ulcer she had ever seen. Nurse #3 described the ulcer as unstageable and reported that it was black and red in some areas and had a foul odor. After Nurse #3 saw the wound, she called the former Director of Nursing (DON) into the room and the former DON placed an antiseptic dressing on the wound. Nurse #3 assumed that the former DON had notified the doctor of Resident #9's pressure ulcer and received an order for the antiseptic dressing. Nurse #3 stated she did not notify the doctor of the pressure ulcer because she had let the former DON know and she thought she was going to take care of it. A phone interview with NA #6 on [DATE] at 7:15 PM revealed she took care of Resident #9 on the night shift and sometimes she came in at 7:00 PM. At first, Resident #9 had a red area that would open and to which they applied cream and ointment. The open area would heal and then re-open whenever he refused to lie down during the day. NA #6 couldn't remember when Resident #9's bottom first looked bad, but she stated that she reported it to Nurse #2 and Nurse #5. NA #6 stated Resident #9's ulcer continued to worsen and had a foul odor. It went from bad to worse in a short period of time, it became dark in color and the drainage was horrible. NA #6 also stated she thought the doctor was aware of Resident #9's pressure ulcer and that he was giving the nurses orders about the treatment for the wound. A phone interview was attempted on [DATE] at 12:01 PM, [DATE] at 12:00 PM and [DATE] at 10:19 AM with the former DON with no return call. A nurse practitioner (NP) note dated [DATE] indicated Resident #9 was seen by the NP for wound to his buttocks. Unstageable wound to one-fourth area of the coccyx, eschar (dead tissue that eventually sloughs off healthy skin after an injury) present to the buttocks and there was also a 2 cm by 2 cm necrotic area to the right heel. Unable to stage wound, recommend he be sent to the hospital for wound evaluation. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Multiple attempts were made to contact the NP, but they were unsuccessful. The NP no longer worked with the Medical Director's team. An interview on [DATE] at 12:25 PM with the Physician Assistant currently working at the facility revealed Resident #9's wound should have been assessed each week by medical staff or a nurse for the size, drainage, type of tissues, signs, and symptoms of infection, and need for debridement. With eschar tissue present, the wound could easily become infected, and she would have debrided the wound or sent Resident #9 out for evaluation. A phone interview with the Medical Director (MD) on [DATE] at 4:22 PM revealed he was aware of open areas on Resident #9's buttocks that recurred due to his non-compliance with offloading and incontinence care, but he wasn't sure about the pressure ulcer that developed right before he was sent out to the hospital. The MD stated Resident #9 had so many co-morbidities and he felt this was likely a terminal ulcer. The MD stated he wasn't surprised the ulcer developed fast, but he couldn't say how fast and to what extent the pressure ulcer had deteriorated. The MD further stated he had expected to be notified of any deterioration/decline in pressure ulcers even though they had expected Resident #9's ulcer to get worse due to his non-compliance. The MD also stated that with his smoking and low albumin level, the pressure ulcer could have opened up pretty readily. He said he didn't feel Resident #9's pressure ulcer progression was avoidable based on his past history, behaviors, and co-morbidities. Resident #9's hospital admission notes dated [DATE] indicated Resident #9 was seen in the Emergency Department for altered mental status. Resident #9 was found to have severe sepsis/septic shock with acute organ dysfunction, an infected decubitus ulcer stage IV, a pressure injury of buttock stage IV, elevated white blood cells indicating an infection, metabolic encephalopathy, acute renal failure superimposed on chronic kidney disease stage 3, intravascular volume depletion (dehydration), and low sodium. The surgical consult for decubitus sacral ulcer determined the ulcer was large, necrotic, and malodorous ulcer with only minimal erythema. Plan was for surgical debridement and diverting colostomy. It was suspected the sacral ulcer was contaminated with stool. Resident #9 was critically ill and at risk for decompensation resulting in end-organ dysfunction. The resident's fevers were up to 103 Fahrenheit due to an infected sacral pressure ulcer. A CT (computed tomography) scan of the sacral pressure ulcer revealed extensive subcutaneous gas formation (deep seeded infection with gas forming organisms) and tunneling upward within the gluteal and above the gluteal tissues. Resident #9 also had a stage 4 pressure ulcer to the right plantar foot and a soft tissue ulcer to the great toe stump. Resident #9's death certificate dated [DATE] indicated the immediate cause of death was cerebral infarction. An interview with the Director of Nursing (DON) on [DATE] at 5:34 PM revealed the nurses were supposed to complete weekly skin checks on each resident but if the resident had a pressure ulcer, the nurses were supposed to bring it to the doctor's attention. Any resident with a pressure ulcer should be referred to the wound doctor for proper treatment and evaluation. The Administrator was notified of Immediate Jeopardy on [DATE] at 12:57 PM. The facility provided the following IJ Removal Plan with the correction date of [DATE]. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	1. Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance: The identified resident (Resident #9) is no longer a resident of the facility. Resident #9 had a wound that increased in size and severity and the facility allegedly failed to identify changes for Resident #9 who was assessed as a high risk for pressure sores and had a history of pressure ulcers. The resident was later discharged to the hospital and was noted to have an infected stage IV pressure ulcer. All other residents have the potential to be affected by the deficient practice. * An immediate skin assessment/total body audit of all residents is being initiated today, [DATE], by the licensed nursing staff and will be completed by [DATE]. * The skin assessment/audit will consist of observation of the current status of the individual resident's skin integrity and compare to the last documented skin assessment for the resident and will be documented on the skin assessment sheet. * Any resident/s with newly developed wounds will be measured and staged by facility employed RN certified wound nurse. * Any resident with any newly developed wounds or worsening wounds, the resident's nurse will inform the DON or DON Designee. Primary Care Provider will be notified immediately by the DON or DON Designee. * Any resident that refuses to have skin assessment, will be asked again by their assigned licensed nurse, and will contact family to see if they can assist in encouraging them to allow us to conduct skin assessment. * If the resident continues to refuse and has a BIMS score of 12 or greater, will be provided with information by the DON or DON Designee regarding the risks of refusing skin assessment or wound care and will be care planned as such. The DON or DON Designee will update the care plan during the weekly Focus meeting if not updated on the care plan at the time of notification. * The Primary Care Provider will be notified by the DON or DON Designee regarding the refusal as well and will be documented in the Care Plan. After 3 separate attempts to encourage the resident to allow, the DON or DON Designee will notify the Primary Care Provider regarding the refusal and will document in the clinical record and the care plan. * All current residents will have an order for or notification on the TAR for weekly skin assessments by [DATE]. The DON or DON Designee will ensure the order is placed on the TAR. The current residents with wounds/pressure sores that need weekly assessment and/or measurements will be documented in Resident/s chart by [DATE]. The DON and/or the RN certified wound care nurse and/or DON designee will ensure the TAR will reflect the documentation of weekly assessment and/or measurements along with the order for the wound care for the individual resident on weekly basis. 2. Actions taken to alter the process or system failure to prevent adverse outcome from occurring or recurring: (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	F. Although contracted wound providers conduct assessments, the licensed staff will continue to be expected to conduct weekly skin assessments and measurements regardless of other wound service providers. G. Licensed nursing staff will be educated to notify the Primary Care Provider if they observe a new pressure wound or open area, any signs of wound infection, any wound deterioration initiated [DATE] by the Director of Nursing (DON) and/or RN certified wound nurse will be conducted to the nursing staff to include nurses and nurse aides and will be completed by [DATE]. H. Licensed nursing staff will be educated to notify the Primary Care Provider if a newly admitted resident is noted to have open wound/pressure sore. The new resident with wound or open area will have orders to conduct weekly skin assessment and measurements on TAR. I. Signs and symptoms of sepsis to include: * Faster heart rate * Reduced urine output * Fever and chills * Difficulty in breathing * Mental confusion * Hyperventilation J. The Nurse Aides will be educated to notify the nurse with any changes in skin integrity immediately to the individual resident's nurse. Such changes as redness, rashes, any skin break, abrasions, or any unusual skin integrity observations that were not noted with skin observations during prior care provided. * The facility will conduct weekly Focus meetings with the Interdisciplinary team (IDT) to discuss any resident wounds and will discuss the interventions put in place and determine if the interventions are beneficial and if not, the DON or DON designee will notify the Primary Care Provider of the status of wound and need for additional wound treatment intervention. This is a process that was in place historically and will be re-implemented. The DON or DON Designee is responsible for ensuring the weekly Focus meetings occur. * The IDT include dietary manager, the registered dietician (when available) DON or DON designee, Administrator, Social Service Director, Activity Director, and nurse and/or nurse aide that are involved in the care of residents. The alleged date of IJ removal is [DATE]. The credible allegation for the immediate jeopardy removal was validated on [DATE] with a removal date of [DATE]. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE], the facility's credible allegation was validated through record reviews and staff interviews. The facility provided education documentation for all staff on identifying and reporting a change in condition especially in skin integrity. In addition, the facility provided signed education sheets on the new system for completing skin assessments. The education provided details on how all new admissions, readmissions would have an initial, weekly, and as needed skin assessments completed by the nurse. Interviews conducted with the nursing staff validated skin assessments were assigned to each resident and were flagged on the Treatment Administration Record (TAR) for the nurse to complete. The nurses interviewed were able to explain the new system implemented by the facility. The nursing aides were interviewed and described the different signs of changes in skin integrity to be reported to the nurse during provision of care. The Director of Nursing (DON) was interviewed and described the way the new system worked to ensure skin assessments were completed. She reported all skin assessments were assigned in the electronic medical record (EMR) on the Treatment Administrator Record (TAR) to be completed by the nurse based on an assignment sheet set up by the DON. She explained she or her designee were responsible for reviewing the assessments daily to ensure all skin assessments had been thoroughly completed. The DON explained she or her designee verified the sheets were completed in detail and not just checked as done. A weekly focus meeting was held on [DATE] which included the Administrator, the Director of Nursing, and the Infection Preventionist. They discussed the following areas: skin observations, wound reports, laboratory audit review/notification, weight loss, change of conditions and acute charting boards. 43332 2. Resident #6 was readmitted from the hospital to the facility on [DATE]. Her cumulative diagnoses included moderate protein-calorie malnutrition, pressure ulcer of right ankle, pressure ulcer left hip, pressure ulcer left ankle, and pressure ulcer right hip. Resident #6's most recent Minimum Data Set (MDS) was a quarterly assessment dated [DATE]. The MDS revealed the resident was cognitively able to make decisions for activities of daily living. Resident #6 required total assistance from one staff member with bed mobili [TRUNCATED]

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43332 Based on staff interviews and record reviews, the facility failed to monitor a resident's weight on a weekly basis as ordered by the physician, identify a severe unintended decline in his weight, and implement/adjust interventions. The resident was sent to the hospital on 4/7/2022 and had a feeding tube placed in the stomach for 1 of 1 resident (Resident #10) reviewed for maintain nutritional status. The facility also failed to provide a physician ordered nutritional supplement for 2 of 2 sample residents (Resident #11 and Resident #2). Immediate Jeopardy began on 3/9/2022 when staff failed to identify a significant weight loss of 11.5% for Resident #10. Resident #10 continued to lose weight and had a cumulative weight loss of 24.4% since 1/19/2022. Immediate Jeopardy was removed as of 6/14/2022 when the facility implemented an acceptable allegation of Immediate Jeopardy removal. The facility remains out of compliance at a scope and severity level E (No actual harm with potential for more than minimal harm that is not immediate jeopardy) for the facility to continue staff education, ensure monitoring systems put into place are effective. The jeopardy tag is left out of compliance at a scope and severity E also for Resident #11 and #2. The findings included: 1. Resident #10 was admitted to the facility on [DATE] with diagnosis of cerebral palsy and intellectual disorders. Resident #10 was [AGE] years old. Resident #10's care plan last updated on included meal satisfaction and by mouth intake. Interventions included add Resident #10 to the meal list of residents needing additional assistance with feeding and weigh/monitor results weekly. Physician diet order initiated on 5/11/2020 read in part No Added Salt diet, dysphagia mechanically altered diet, thin consistency related to cerebral palsy. The order was active on resident's discharge date of [DATE]. Physician order initiated on 4/21/2021 read in part weekly weights every day shift every Wednesday for weight monitoring. The order was active on resident's discharge date of [DATE]. Physician order initiated on 9/8/21 read in part add magic cup frozen nutritional treat every lunch for nutritional support. The order was active on resident's discharge date of [DATE]. Resident #10's quarterly MDS dated [DATE] indicated resident was not cognitively intact for daily decision making. Resident #10's height was 61 inches and he weighed 124 pounds. Resident diet included therapeutic and mechanically altered diet. The MDS indicated Resident #10 was assessed for total dependence on one staff member for assistance with eating. Resident #10 had no weight loss or gain since the previous review. The MDS further indicated Resident #10 had limited range of motion on both sides of his upper and lower extremities. Nurse's progress note dated 1/5/2022 showed Resident #10 was diagnosed with COVID-19. Resident #10 remained in the facility. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #10's electronic medical record, on the vital sign tab which included weights showed his weight documented as 125.7 pounds on 1/19/2022, weight collected by mechanical lift. Review of January 2022 Medication Administration Record (MAR) revealed no documentation of weights on 1/26/2022. A review was conducted of Resident #10's meal intake records for January 2022 revealed his intake as resident refused on 11 occasions (15% of the meals documented), 0-25% of the meal was consumed on 31 occasions (44% of the meals documented), 26-50% of the meal was consumed on 13 occasions (18% of the meals documented), 51-75% of the meal was consumed on 12 occasions (17% of the meals documented), and 76-100% of the meal was consumed on 4 occasions (6% of the meals documented). Review of February 2022 MAR revealed no information of weekly weights was recorded for the month. A review was conducted of Resident #10's meal intake records for February 2022 revealed his intake as resident refused on 7 occasions (9% of the meals documented), 0-25% of the meal was consumed on 16 occasions (21% of the meals documented), 26-50% of the meal was consumed on 15 occasions 20(% of the meals documented), 51-75% of the meal was consumed on 24 occasions (32% of the meals documented), and 76-100% of the meal was consumed on 13 occasions (17% of the meals documented). Resident #10's care plan was updated on 3/3/2022 included an area of focus for difficulty swallowing related to dysphagia, cerebral palsy, and mental disorder. On review of the care plan history updates, there was no update completed on 3/3/2022, unable to identify staff who made the update to the care plan. Dietician note dated 3/3/2022 showed Resident #10 was stable with weight for greater than 6 months, he was fed by staff, and received a magic cup with lunch daily. The Dietician's documentation stated no acute nutrition concerns at this time. Will continue current diet/supplement regimen and will follow up as needed. A telephone interview was conducted on 6/8/2022 at 4:15PM with the facility's Consultant Registered Dietician (RD). During the interview, RD stated Resident #10 had a significant weight change from 1/19/2022 to 3/9/2022. The RD indicated she started working at the facility in January 2022 and at that time, she was contacted by facility staff through email, telephone, or text when a resident had a significant weight change. The RD further stated she had not received notifications from staff about Resident #10's weight change. During the interview the RD stated when she completed the dietary assessment in March, there was no documentation in Resident #10's medical record that stated he had a weight decrease. The RD further stated she ran a weight report at the beginning of each month and stated Resident #10 weight change would have showed on the report she ran when she returned to the facility on [DATE]. Resident #10 had been discharged on [DATE]. Resident #10's annual MDS dated [DATE] indicated Resident #10 had a weight of 126 pounds and was on a mechanical altered and therapeutic diet. The MDS further stated Resident #10 had not had a weight loss of 5% in the last month or a weight loss of 10% in the last 6 months. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A follow up interview conducted on 6/13/2022 at 10:28 A.M. with the RD revealed she was responsible to complete the weight section on the MDS. During the interview she stated she used the last weight available in Resident #10's medical chart. The weight used for the March MDS was from January 2022 and was recorded as 125.7 pounds, which she rounded up to 126 pounds. Review of March 2022 MAR revealed no documentation on 3/2/2022. The weight documented on 3/9/2022 was 111.2 pounds and documented on 3/23/2022 as 112.3 pounds. Resident #10 refused to be weighed on 3/16/2022 and 3/30/2022. Attempts were made to interview Nurse #1 who entered the weights for Resident #10 on 3/9/2022 and 3/23/2022, via telephone were unsuccessful. A review was conducted of Resident #10's meal intake records for March 2022 revealed his intake as resident refused on 7 occasions (11% of the meals documented), 0-25% of the meal was consumed on 11 occasions (17% of the meals documented), 26-50% of the meal was consumed on 13 occasions (20% of the meals documented), 51-75% of the meal was consumed on 15 occasions (23% of the meals documented), and 76-100% of the meal was consumed on 20 occasions (30% of the meals documented). Resident #10 weighed 111.2 pounds collected by mechanical lift on 3/9/2022. (representing an 11.5% weight loss since 1/19/2022). Resident #10 weighed 95 pounds on 4/6/2022, undocumented how the weight was collected. (representing a 24.4% weight loss since 1/19/2022). An interview was conducted on 6/8/2022 at 3:11 P.M. with the Unit Manager, who weighed Resident #6 on 4/6/2022. The Unit Manager stated she started working at the facility the end of March 2022 and had identified ordered weights missing for residents. The Unit Manager further stated the resident's assigned nurse was responsible to have the NA weigh residents on days the resident weights were ordered. She then revealed, the assigned nurse was responsible for either documenting the resident's weight or giving the information to the Unit Manager and she documented the resident's weight into the resident's medical record. During the interview the Unit Manager stated she ran a report each month to identify missing weights and followed up with the assigned nurse to ensure the resident weights were collected. After reviewing Resident #10's medical record, the Unit Manager stated she was unsure why there were so many missing weights for Resident #10. The Unit Manager then revealed maybe the weights had been collected and not documented in the system; however, she is unaware of any paperwork at the facility with resident weights listed that have not been entered. During the interview the Unit Manager revealed with the variation from one weight to the next, Resident #10 should have been reweighed. She further stated she was unsure if a reweigh was completed on Resident #10 but based off the medical record it appeared a reweigh was not completed and she was unsure why it was not done. During the interview the Unit Manager stated Resident #10 was a little guy, but she was not familiar enough with the resident to visually recognize he had lost weight. Lab test for Comprehensive Metabolic Panel (CMP) was ordered and collected on 3/11/22. The lab results were completed on 3/12/22 and there is a fax date stamp on the top of the lab results that reads Sat [DATE]:07:16 2022. The lab results revealed an abnormal level of potassium 6.1 millimoles per Liter (mmol/L) (normal range is 3.5-5.1 mmol/L) and albumin 3.2 grams per deciliter (g/dL) (normal range is 3.5-5. 7g/dL). The lab results report was initiated and dated 3/17/22. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Nurse Practitioner Progress note dated 4/7/2022 indicated Resident #10 had a 16-pound weight loss. Under Assessment and Plan for significant weight loss the note reads in part Periods of agitation. Requires assistance with ADL's (activities of daily living). Monitor weight. Monitor consumption of meals. Lab results dated 3/11/22 included in progress note. Attempts were made to interview Nurse Practitioner via telephone were unsuccessful. An interview conducted on 6/8/2022 at 3:19 P.M. with Nurse #10. During the interview, Nurse #10 stated nurses provided NAs with a list at the beginning of the shift with residents who had weights ordered for that day. The NAs weighed the residents and gave the information back to the nurse to document in the resident's medical record. She further stated the former unit manager completed reweighs for residents with weight alerts triggered by the medical chart. She stated the medical chart alerted the use of significant weight changes from the previous entry. When staff received this alert, they informed the former Unit Manager. The Unit Manager completed a reweigh to verify a weight change had occurred. The Physician and RD were made aware of weight changes alerted through the medical record computerized system when the reweigh confirmed a weight change. Nurse #10 stated she was familiar with the resident and had not observed him to have a weight loss. When she reviewed his medical chart, she stated Resident #10 had a significant weight loss and she was unsure what caused him to lose the weight. An interview was conducted on 6/10/2022 at 9:32 A.M. with Nurse #5. During the interview Nurse #5 stated she had provided care to Resident #10 in the months prior to him being discharged from the facility. She stated she had not noticed any change in his eating pattern or any change in his weight. An interview was conducted on 6/11/2022 at 6:57 A.M. with Nurse Aide (NA) #7. During the interview, NA #7 stated she was familiar with Resident #10. She stated Resident #10 was able to hold his food and feed himself finger foods that included cakes, half of a sandwich, and soda cans. An interview was conducted on 6/11/2022 at 7:19 A.M. with NA #6. During the interview NA #6 stated she stayed in the room and assisted Resident #10 with eating. When he was given something in his hand, he was able to hold the item and feed himself. She stated if Resident #10 wanted a snack offered to him, he took the snack from staff and ate it. When Resident #10 refused the snack, he threw the snack on the floor. NA #6 revealed Resident #10 ate most of the food provided to him. During the interview, NA #6 stated she had not observed any weight loss for Resident #10. An interview was conducted on 6/11/2022 at 8:08 A.M. with Nurse#2. During the interview, Nurse #2 stated Resident #10 looked different and appeared to have had a weight loss prior to his discharge to the hospital (on 4/7/22). Nurse #2 stated she was unsure how much Resident #10 ate for mealtime, however, stated he ate snacks on third shift. During the interview, Nurse #2 revealed on 4/7/2022 at the start of her 7 P.M. to 7 A. M. shift, she entered Resident #10's room and told him Hello. She revealed when she spoke to Resident #10, he did not respond to her greeting. Nurse #2 stated this was not normal for Resident #10 and she went to his bedside to assess him. Nurse #2 stated she completed a set of vital signs which were within Resident #10's normal range. During the interview, Nurse #2 stated due to Resident #10's lack of a verbal response, she felt something was wrong and had Resident #10 sent to the emergency department for evaluation. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #10 was admitted to the Hospital on 4/7/2022 with a chief complaint of altered mental status. The physician examination completed in the emergency department on 4/7/2022 at 8:50 P.M. revealed Resident #10 weighed 95 pounds. A nutrition consultation was ordered. Resident #10 was admitted to the hospital on 4/7/2022 with a primary diagnosis of hypernatremia (elevated sodium level). The medical records reviewed showed Resident #10 had a feeding tube inserted through his nose to his stomach (nasogastric tube). On 4/10/2022 an x-ray was ordered and completed for a tube check to verify placement of the nasogastric tube. The x-ray findings revealed a small bowel feeding tube ended in Resident #10's stomach. A review of the hospital course indicated the resident underwent a successful PEG tube placement (feeding tube placed directly into the stomach) on 4/18/2022. The resident was discharged on [DATE] to another skilled nursing facility. Resident #10 had a discharge weight of 104 pounds. An interview was conducted on 6/11/2022 at 5:02PM with the Regional Nurse Consultant revealed expectations would be to monitor weights, provide interventions for weight loss and notify responsible parties to include the MD and Responsible Party. On 6/11/2022 at 5:55 P.M., the facility's Regional Nurse Consultant and Director of Nursing were informed of the immediate jeopardy. The facility provided an acceptable credible allegation of Immediate Jeopardy removal on 6/14/2022. The allegation of immediate jeopardy removal indicated: Credible Allegation of Immediate Jeopardy Removal for F692 1. Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance: The identified resident (Resident #10) is no longer a resident of the facility. Resident #10 had a 24.4 % weight loss from January to April with no identification or assessment of weight loss during time of his loss of weight to determine avoidability. All other residents have the potential to be affected by the deficient practice. There is question as to accuracy of weights, therefore the scale has now been recalibrated and all residents will be weighed today 6. 12.2022. This will assist in identifying residents that have any weight loss and any discrepancies from last weight to today's weight will be addressed with MD and resident representative being notified today. Other residents were identified as having significant weight loss. We have had 3 residents refuse weight to be obtained. We will ask them again and will contact family to see if they can assist in encouraging them to be weighed. Their responsible representatives and MD are being notified. The Registered Dietician was on the IDT call today and will be reviewing each individual resident to determine appropriate interventions and the MD will be made aware of recommendation and the MD will determine if appropriate. The IDT team will meet again tomorrow, 6.13.2022 to review all the interventions. 2. Actions taken to alter the process or system failure to prevent adverse outcome from occurring or recurring: (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Immediate inservice initiated 6/11/2022 by the Director of Nursing (DON) and/or the Corporate Nurse Consultant to the nursing staff to include nurses and nurse aides to ensure that all residents are weighed on an at least monthly basis. The inservice will also include dietary staff and the interdisciplinary team, including the registered dietician, certified dietary manager and therapists that are involved in the care of the residents. The inservice will be conducted in person, telephone, email or text. Those staff members that will have inservice that was not able to be conducted in person, will be acknowledged on the sign in sheet inservice sheet as to the method of communication conveyed. All staff will have evidence of inservice communication by 6.12.2022 and will have the inperson inservice prior to their working shift with signatures on the sign in sheet prior to them working their shift. All newly hired staff (nurses and nurse aides) along with any agency staff will receive the information contained in the inservice prior to working with residents. Any resident that has a physician order or intervention to weigh more frequently, will be weighed at the intervals specific to the individual resident. If there is a weight discrepancy of 5 pounds greater or less than the previous weight obtained, the staff member will reweigh and inform the charge nurse. The charge nurse in turn will inform the Unit Manager or the DON or the DON designee of the weight discrepancy. The Unit Manager and/or the DON and/or the DON designee will notify the MD and responsible party of any weight loss and will put in place an immediate intervention to prevent further weight loss and to attain optimum weight gain based on the Registered Dietician and/or MD recommendations. The Registered Dietician will be contacted by phone and or email by the DON or DON designee with any identified weight changes to address and assist with the interventions and resolution. Audit of all residents' weights will be initiated 6/11/2022 by the (DON) and/or Certified Dietary Manager, and/or the Corporate Nurse Consultant and completed 6/12/2022 to determine if any residents have had any weight loss since last weight obtained. The audit will consist of review of documented weights from the last 2 months to determine if any weight discrepancies are identified. The weight scale was calibrated last evening 6.11.2022 by the Maintenance Director to ensure the accuracy of the scale prior to the new weights to be obtained. Any weights ordered by the MD more often than once a month will be addressed to ensure ongoing compliance with order for more frequent weights. A list will be updated an placed at the nurse's station for the nurses and nurse aides reference. The DON or DON designee will notify the RD within 24 hours or the next business day of any resident with identified weight loss. The RD will assist with interventions and recommendations for weight gain goals. If any residents are identified to have greater than 5 pound weight loss or greater, the MD and responsible party will be notified by the UM and/or DON and/or DON Designee and immediate interventions will be put in place to prevent further weight loss. Any resident with identified weight loss will be weighed weekly until they meet their weight goal based on their usual body weight or their individual desired weight with the RD and/or MD input are attained and maintained for 90 consecutive days. The determination of utilizing the individual resident weight gain goals will be based on their preference of desired weight goal, their usual body weight based on their preference with input from RD. If any resident is identified to have continued weight loss, the MD will be immediately notified by the Unit Manager and/or the DON and/or DON designee to determine if there were any underlying pathology that would contribute to continued weight loss. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility will conduct weekly Focus meetings with the Interdisciplinary team to discuss any resident weight losses and will discuss the interventions put in place and determine if the interventions are beneficial until the resident meets their or desired body weight. If interventions are not reflective of achieving desired results, the interventions will be re-addressed and potential to add or eliminate and replace interventions as appropriate to achieve weight gain goals. Date of corrective action completion Immediate Jeopardy Removal date will be 6/14/2022 The facility's credible allegation of Immediate Jeopardy removal was validated on 6/16/2022. The validation was evidenced by staff interviews, record reviews and review of inservice attendance sheets to verify education had been provided to staff that addressed a new system of identifying and treating weight loss. The interventions included the weight scales and platform scales were recalculated to ensure weight accuracy, residents were weighed and residents with a significant weight loss were reweighed to ensure weight loss, the Registered Dietician will consult the weight loss and offer recommendations (more frequent weights, supplements and therapy screens) the Medical Director and Responsible Parties will be notified, residents medical records were reviewed to ensure interventions had been put in place, weekly weight meetings will be held by the IDT to discuss weight loss. The Administrator notified of the credible allegation for the removal of immediate jeopardy for the removal date of 06/14/22 was validated on 06/16/22. The Administrator stated she would be responsible to ensure the compliance would be maintained. 32394 2. Resident #11 was admitted to the facility on [DATE] from a hospital. Her cumulative diagnoses included mild cognitive impairment and hemiplegia (severe or complete loss of strength on one side of the body) / hemiparesis (mild or partial weakness or loss of strength on one side of the body) following an intracranial hemorrhage affecting her left non-dominant side. An intracranial hemorrhage refers to bleeding inside the skull, which can lead to rapid brain damage or death. The resident's admission orders included a No Added Salt (NAS) diet with regular textures. Her weight was reported to be 121.5 pounds (#) on 11/23/21. The facility's consultant Registered Dietitian (RD) completed a nutritional assessment on 11/29/21. Her comments included, Spoke with resident this morning. Resident reports not liking the food as it is flavorless and she refuses to eat anything until it tastes better. She reports liking Ensure and said she will drink that if it is brought to her. Recommend adding Ensure and liberalizing diet d/t (due to) poor PO (oral) intake. Calories are for maintenance. The RD recommendations also included liberalizing Resident #11 ' s diet due to her poor oral intake. On 12/14/21, the resident's physician ordered a Regular diet with regular textures to be provided. The order also indicated an Ensure shake (a high calorie, high protein nutritional supplement) should be added to all meal trays until the resident's intake at meal times was consistently greater than 75%. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review of Resident #11's care plan included an area of focus indicating the resident had a potential nutritional problem related to dementia and medication use (initiated on 12/19/21). The care plan interventions indicated the facility would provide her diet as ordered, monitor and record intake for every meal, and provide supplements as ordered. A verbal order was again received by the provider on 1/7/22 to provide Ensure with meals for poor to no meal intake. The order included a notation which read, Please ensure patient receives at meal time. Resident #11's most recent Minimum Data Set (MDS) was a quarterly assessment dated [DATE]. The resident was assessed to have intact cognitive skills and was reported to be independent with eating. She was noted to be 68 inches tall and 117#. The resident weights also included, in part: 119.0# on 5/1/22 and 121.0# on 6/6/22 (her most recent weight). A review was conducted of Resident #11's meal intake records from the past 30 days revealed her intake as: --0-25% of the meal was consumed on 3 occasions (4% of the meals documented); --26-50% of the meal was consumed on 6 occasions (8% of the meals documented); --51-75% of the meal was consumed on 36 occasions (48% of the meals documented); --76-100% of the meal was consumed on 30 occasions (40% of the meals documented). An observation was conducted on 6/8/22 at 8:40 AM of Resident #11 as she was sitting in her room with her breakfast meal tray placed on the tray table beside her. The top of her meal ticket read, add house shake with all meal trays. There was no House Shake nor any other nutritional supplement on her meal tray. Upon inquiry, the resident confirmed she did not receive a nutritional supplement with the meal. An observation was conducted on 6/8/22 at 12:35 PM as Resident #11 was sitting in her wheelchair eating a sub sandwich brought from outside the facility. No House Shake or nutritional supplement was seen at the time of the observation. When asked, the resident stated a nutritional supplement was neither brought into her room nor offered to her. An observation was conducted on 6/9/22 at 8:37 AM as Resident #11 was sitting in her room with her breakfast meal tray placed on the bedside tray table beside her. The top of her meal ticket read, add house shake with all meal trays. There was no House Shake nor any other nutritional supplement on her meal tray. Upon inquiry, the resident reported she loved the nutritional supplement but had not received one over the last 3 days. An observation was conducted on 6/9/22 at 12:15 PM as Resident #11's meal tray was delivered to her. There was no House Shake nor any other nutritional supplement observed on her meal tray. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review of Resident #11's June 2022 Medication Administration Record (MAR) was conducted on 6/9/22. The MAR indicated Resident #11 last received the Ensure nutritional supplement with her morning meal on 6/7/22. The documentation showed Ensure was not provided with the last 7 consecutive meals served (beginning with lunch on 6/7/22 and through lunch on 6/9/22). An interview was conducted on 6/9/22 at 2:20 PM with the Dietary Manager. During the interview, the Dietary Manager reviewed the Dietary Department's list of nutritional supplements ordered for residents. She stated, I do not have anything for them (including a reference to Resident #11) they do not get supplements from me. Upon inquiry, the Dietary Manager indicated commercial nutritional supplements such as Ensure were provided from the Nursing Department. When asked what the House Shake would be, the Dietary Manager reported she was not sure and stated Resident #11's meal ticket was not correct because the physician's order was actually for Ensure. An interview was conducted on 6/9/22 at 5:11 PM with the facility's Unit Manager. During the interview, the Unit Manager was asked who was responsible for ensuring Resident #11 received a nutritional supplement such as Ensure. She stated the hall nurse was responsible for this and added that if the resident refused the supplement, the refusal needed to be documented in the resident's medical record and the physician notified. At that time, the Unit Manager was shown documentation on Resident #11's June 2022 MAR which indicated Resident #11 had last received Ensure on the morning of 6/7/22. Accompanied by the Unit Manager on 6/9/22 at 5:15 PM, an observation was made of the contents of the nursing station refrigerator. The Unit Manager reported Ensure was typically stored in the refrigerator. However, no Ensure was found stored in the refrigerator; she then reported there was no Ensure in stock at the facility. The Unit Manager stated she knew Resident #11 loved this nutritional supplement and was not even particular about the flavor she received. When asked what needed to be done at this point, the Unit Manager reported the provider and consultant RD needed to be notified Ensure was out of stock to see if there was an appropriate alternative that could be offered to Resident #11 until the Ensure came in. An interview was conducted with the facility's interim Administrator on 6/9/22 at 5:45 PM. During the interview, concerns were expressed regarding failure of Resident #11 to receive a nutritional supplement prescribed three times daily. The interim Administrator stated he would expect a nutritional supplement to either be available in-house or the physician to be contacted for an acceptable, alternative supplement to be selected. 3. Resident #2 was admitted to the facility on [DATE]. His cumulative diagnoses included diabetes, dysphagia (difficulty swallowing), hemiplegia (severe or complete loss of strength on one side of the body) / hemiparesis (mild or partial weakness or loss of strength on one side of the body) following a cerebral infarction (stroke) affecting his left non-dominant side; and vascular dementia with behavioral disturbance. A Nutrition Note dated 1/17/22 and authored by the facility's Registered Dietitian (RD) reported the resident received Magic Cup as a nutritional supplement. His most recent weight was noted as 142 pounds (#) on 1/12/22. Another Nutrition Note authored by the RD on 4/8/22 reported the resident's current weight was 144# and had remained stable over the past 6 months. This note also indicated Resident #2 received Magic Cup as a nutritional supplement. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #2's most recent Minimum Data Set (MDS) was a quarterly assessment dated [DATE]. The resident had moderately impaired cognitive skills for daily decision making. The assessment reported Resident #2 required extensive assistance from staff with one person physical assistance. He was 69 inches tall and weighed 144#. He received a therapeutic and mechanically altered diet. A review of the resident's care plan included an area of focus which indicated he was at nutrition risk related to the diagnosis of dysphagia and status post removal of a percutaneous tube (a surgically placed tube used to deliver nutrition), placing him at risk for aspiration (initiated on 4/19/21). The resident was sent out to the hospital on 5/22/22 with re-entry to the facility on [DATE]. Resident #2 ' s re-admission orders (dated 5/26/22) included a Consistent Carbohydrate diet with mechanical soft textures and nectar/mildly thick consistency liquids; add large portions at breakfast to aid in meeting needs. His current physician orders also included an order for a frozen nutritional cup / treat once daily with lunch for nutritional support supplementation (initiated on 9/13/21). The resident's most recent weight was recorded on 6/12/22 as 138.0#. An observation was conducted on 6/9/22 at 12:16 PM as Resident #2 was lying in bed with his head of bed raised and a lunch meal tray placed on the bedside tray table in front of him. The resident's meal ticket included a notation to send a frozen nutritional treat every day with lunch. No frozen nutritional cup/treat was on his meal tray. An interview was conducted on 6/9/22 at 2:20 PM with the Dietary Manager. During the interview, the Dietary Manager reviewed the Dietary Department's list of nutritional supplements ordered for residents. She stated, I do not have anything for them (including a reference to Resident #2)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43332 Based on observations, record review, staff interviews, and Wound Physician interview, the facility failed to follow the physician's order for the maintenance of a PEG (percutaneous epigastric) tube (feeding tube placed in the stomach) for 1 of 1 sampled resident (Resident #6). The findings included: Resident #6 was admitted to the facility on [DATE] as a reentry from the hospital. Her cumulative diagnoses included moderate protein-calorie malnutrition, anorexia, and adult failure to thrive. A review of Resident #6's most recent care plan initiated on 3/1/2022 included an area of focus which indicated the resident required overnight tube feeding related to adult failure to thrive and she received a regular diet. The interventions included treatment as ordered to PEG tube site. A review of physician orders dated 3/2/2022 revealed change PEG tube insertion site with 0.125 % sodium hypochlorite solution (antiseptic solution), apply silver alginate and split gauze and change daily every shift. An observation was conducted on 6/9/2022 3:48 PM of a wound treatment dressing change. The Wound Physician removed Resident #6's existing dressing and placed a wet gauze over the PEG tube insertion site at the end of the evaluation. The Unit Manager collected and prepared supplied to provide wound treatment for Resident #6. The Unit Manager washed her hands with soap and water, applied clean gloves, and removed the gauze from the PEG tube insertion site. The Unit Manager applied clean gloves and cleansed the area around the PEG tube with a gauze soaked with 0.125% sodium hypochlorite solution. The Unit Manager applied a split 4x4 gauze around the PEG tube and used tape to secure. The tape was dated with the current date and Unit Mangers initials. An interview was conducted on 6/10/2022 at 8:46 A.M. with the Unit Manager. During the interview the Unit Manager stated yesterday (6/9/2022), she applied a split 4x4 gauze around Resident #6's PEG tube insertion site. The physician order was reviewed with the Unit Manager. She stated the dressing for the PEG tube insertion site was calcium alginate with silver and split gauze. During the interview the Unit Manager stated she had not applied the right dressing to the PEG tube insertion site. She stated she thought the physician had ordered 4x4 split gauze. An interview conducted on 6/10/2022 at 4:40 P.M. with the Director of Nursing (DON). During the interview, the DON revealed staff were responsible to review each wound treatment order prior to each resident wound treatment and she expected staff to follow the physician wound treatment orders. The DON stated she was unsure why the Unit Manager applied a dressing that was different than the physician's order. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Ivy at Gastonia LLC	4414 Wilkinson Blvd Gastonia, NC 28056

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview conducted on 6/13/2022 at 8:53 A.M. with the Wound Physician. During the interview, the Wound Physician stated the calcium alginate with silver was used with a 4x4 gauze on Resident #6's PEG tube insertion site to assist with the collection of wound drainage from the site. The Wound Physician stated there was no harm to the resident by not having the calcium alginate with silver applied around the PEG tube insertion site.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32394 Based on observations, resident and staff interviews, and record reviews, the facility failed to provide all of the food items as specified by the planned menu for 3 of 7 residents (Resident #12, Resident #11 and Resident #2) during 4 of 4 meal observations conducted. The findings included: 1. Resident #12 was admitted to the facility on [DATE] from a hospital. The resident's admission Minimum Data Set (MDS) dated [DATE] indicated he had moderately impaired cognitive skills for daily decision making. Resident #12's current diet order (dated 5/13/22) was a Regular diet with regular textures. An observation was conducted on 6/8/22 at 8:35 AM as Resident #12 sat in his room with his breakfast meal placed on the bedside tray table. The resident's meal ticket on his tray indicated the meal consisted of the following: orange juice; sausage, egg and cheese bake; biscuit; margarine; oatmeal; whole milk; coffee; and fruit jelly. The resident reported he did not receive milk with his breakfast. The observation of his meal tray confirmed milk was not sent in a carton or a glass. The resident reported he would like to have received milk with his breakfast. A mealtime observation was conducted on 6/8/22 at 12:30 PM of Resident #12 in his room after he had received his lunch meal tray. The resident's meal ticket placed on his tray indicated his meal included: [NAME] Dijon pork loin; buttered red potatoes; buttered broccoli florets; dinner roll; margarine; chocolate pudding; whole milk; and coffee. The observation revealed Resident #12 did not receive milk with his meal. Upon inquiry, the resident stated he would have liked to have milk with his meal. An observation was conducted on 6/9/22 at 8:47 AM at 8:47 AM of Resident #12 after his breakfast meal tray was delivered to his room. The resident's meal ticket on his tray indicated the meal consisted of the following: orange juice; scrambled egg; bran muffin; margarine; grits; whole milk; coffee; and fruit jelly. No milk was served on his meal tray. Resident #12 stated he would have liked to receive milk with his breakfast meal. A lunch time observation was conducted on 6/9/22 at 12:17 PM as Resident #12 ' s meal tray was delivered to his room. The resident's meal ticket placed on his tray indicated his meal included: lasagna; buttered Italian green beans; garlic French bread; strawberry shortcake; whole milk; and coffee. The resident was observed as he compared his meal ticket to the items on his meal tray. Resident #12 reported he was again missing milk from his meal and confirmed he was also missing the strawberry shortcake. The resident stated, Someone else must have gotten my strawberry shortcake. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 6/9/22 at 2:20 PM with the Dietary Manager. During the interview, concerns regarding the mealtime observations were discussed. These concerns included failure of the residents to receive the food items as planned for their meal and as indicated by the meal ticket on the resident's tray. The Dietary Manager reported she would expect a resident to receive milk as well as the other food items as indicated by their meal ticket. An interview was conducted on 6/9/22 at 5:45 PM with the facility's interim Administrator. Upon inquiry, the interim Administrator stated, I would expect the meal ticket to reflect what the meal is. 2. Resident #11 was admitted to the facility on [DATE] from a hospital. The resident's current diet order (initiated 12/14/21) was a Regular diet with regular textures. Resident #11's most recent Minimum Data Set (MDS) was a quarterly assessment dated [DATE]. The resident was assessed to have intact cognitive skills for daily decision making. An observation was conducted on 6/8/22 at 8:40 AM of Resident #11 as she was sitting in her room with her breakfast tray placed on the tray table beside her. The resident's meal ticket on her tray indicated the meal consisted of the following: apple juice; scrambled egg; biscuit; margarine; assorted cold cereal; whole milk; coffee; and fruit jelly. An observation of Resident #11's meal tray revealed she received a glass of juice, scrambled egg with small pieces of sausage (sausage, egg and cheese bake), biscuit, margarine, oatmeal, coffee and jelly. Notations on the bottom of Resident #11's meal ticket read in part, No oatmeal. Upon inquiry, the resident stated she did not receive milk or cold cereal with her breakfast (confirmed by the observation of her meal tray). She reported she would have liked to receive milk and expressed frustration upon receiving oatmeal with her meal stating, They know I don't like oatmeal. An interview was conducted on 6/9/22 at 2:20 PM with the Dietary Manager. During the interview, concerns regarding the mealtime observations were discussed. These concerns included failure of the residents to receive the food items as planned for their meal and as indicated by the meal ticket on the resident's tray. The Dietary Manager reported she would expect a resident to receive milk and the other food items as indicated by their meal ticket. An interview was conducted on 6/9/22 at 5:45 PM with the facility's interim Administrator. Concerns identified during the meal observations were discussed and included missing menu items from the meal tray (specifically milk) and food preferences not being honored. Upon inquiry, the interim Administrator stated, I would expect the meal ticket to reflect what the meal is. He also reported he would expect a resident's food preferences to be honored. 3. Resident #2 was admitted to the facility on [DATE]. His cumulative diagnoses included diabetes, dysphagia (difficulty swallowing), hemiplegia (severe or complete loss of strength on one side of the body) / hemiparesis (mild or partial weakness or loss of strength on one side of the body) following a cerebral infarction (stroke) affecting his left non-dominant side; and vascular dementia with behavioral disturbance. The resident's most recent Minimum Data Set (MDS) was a quarterly assessment dated [DATE]. The resident had moderately impaired cognitive skills for daily decision making. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #2's physician orders dated 5/26/22 included a Consistent Carbohydrate diet with mechanical soft textures and nectar/mildly thick consistency liquids; add large portions at breakfast to aid in meeting needs. An observation was conducted and an interview attempted with Resident #2 on 6/9/22 at 8:43 AM as the resident was lying in bed with his head of bed raised and a bedside tray table placed in front of him. An 8-ounce empty glass with an orange-appearing liquid at the bottom of the glass was observed to be on his tray table. His breakfast meal tray was on the high boy cart placed outside of his room. An observation of Resident #2's meal tray revealed there was no milk carton or glass for milk on the tray. His meal tray was observed to include a partially eaten slice of bread (approximately 25% consumed), scrambled eggs (0% consumed), and grits (0% consumed). Resident #2's meal ticket indicated he should have been sent the following food items: orange juice (nectar-thickened), scrambled egg, buttered wheat toast (no hard crust), margarine, grits, and whole milk (nectar-thickened). The observation of his meal tray revealed no milk had been sent for Resident #2's breakfast. An interview was conducted on 6/9/22 at 2:20 PM with the Dietary Manager. During the interview, concerns regarding the mealtime observations were discussed. These concerns included failure of the residents to receive the food items as planned for their meal and as indicated by the meal ticket on the resident's tray. The Dietary Manager reported she would expect a resident to receive milk and the other food items as indicated by their meal ticket. An interview was conducted on 6/9/22 at 5:45 PM with the facility's interim Administrator. Upon inquiry, the interim Administrator stated, I would expect the meal ticket to reflect what the meal is.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 32394 Based on observations, staff and consultant Registered Dietitian (RD) interviews and record review, the facility failed to serve a nourishing evening snack and obtain resident group approval for greater than 14 hours to elapse between the provision of a substantial evening meal and breakfast the following day for residents residing on 3 of 3 resident hallways (300 Hall, 200 Hall and 100 Hall). The findings included: A review of the facility's Tray Cart Delivery Schedule indicated the meal cart delivery times were scheduled as follows: --The meal cart for the 300 Hall was scheduled to be delivered at 5:00 PM for Dinner and at 8:00 AM for Breakfast (indicative of a 15 hour time span between the two meals); --The meal cart for the 200 Hall was scheduled to be delivered at 5:10 PM for Dinner and at 8:20 AM for Breakfast (indicative of a 15 hour and 10 minute time span between the two meals); --The meal cart for the 100 Hall was scheduled to be delivered at 5:20 PM for Dinner and at 8:10 AM for Breakfast (indicative of a 14 hour and 50 minute time span between the two meals). An interview was conducted on 6/8/22 at 3:17 PM with the facility's Activities Director (AD). During the interview, the AD reported she worked in the Dietary Department at the facility for 2-3 months, beginning in October 2021. She has worked as the AD since February of 2022. As the AD, she was responsible for assisting Resident Council with their monthly meetings. When asked, the AD reported she was not aware of any meal schedule changes made or discussed in Resident Council meetings since she had worked at the facility. An interview was conducted on 6/8/22 at 3:25 PM with the facility's Dietary Manager. During the interview, the Dietary Manager was asked if she had adjusted the meal schedule since she came to the facility in September 2021. The Dietary Manager stated she had not changed the scheduled meal cart delivery times. The extended time span (greater than 14 hours) noted between the evening meal and breakfast meal of the following day was then discussed. When asked about the meal times, the Dietary Manager stated she noticed the extended time span between the residents' Dinner and Breakfast meals when she first came to work at the facility but was told that was how it had always been. The Dietary Manager reported snacks were sent out to the facility's one Nursing station each evening. These snacks included fudge rounds and cakes, sandwich cookies, peanut butter crackers, animal crackers, graham crackers, and a total of 7 sandwiches cut into halves. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A telephone interview was conducted on 6/8/22 at 4:25 PM with the facility's consultant Registered Dietitian (RD). The RD reported she began consulting to the facility in January of 2022. When asked about the facility's meal schedule allowing greater than 14 hours to elapse between the provision of a substantial evening meal and breakfast the following day, the RD stated, It's all on the Dietary Manager. When asked if she was aware of a 15-hour time span between Dinner and Breakfast the next day, the RD stated she was not. She reported the facility was short-staffed when she started at the facility in January 2022 and has had a lot of staff transitions ever since. The RD stressed she worked in a strictly clinical role at the facility. An interview was conducted on 6/8/22 at 4:45 PM with the facility's interim Administrator. During the interview, the failure of the facility to provide meals within a time span specified by the regulations was discussed. At that time, the Administrator stated that schedule was not acceptable. He reported he was not aware there was an extended period of time between the residents ' Dinner and Breakfast meal of the following day. When asked, the Administrator reported his expectation was that no more than 14 hours would elapse between the Dinner and Breakfast meals.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32394 Based on observations, staff interviews and record review, the facility failed to provide adaptive eating utensils as ordered by the physician for 1 of 1 resident (Resident #2) requiring adaptive equipment at mealtime. The findings included: Resident #2 was admitted to the facility on [DATE]. His cumulative diagnoses included diabetes, dysphagia (difficulty swallowing), rheumatoid arthritis, and hemiplegia (severe or complete loss of strength on one side of the body) / hemiparesis (mild or partial weakness or loss of strength on one side of the body) following a cerebral infarction (stroke) affecting his left non-dominant side; and vascular dementia with behavioral disturbance. The resident's physician orders dated 3/19/21 included an order for built up curved utensils for all meals (initiated on 3/19/21 and continued as an active order). Resident #2's most recent Minimum Data Set (MDS) was a quarterly assessment dated [DATE]. The resident had moderately impaired cognitive skills for daily decision making. The assessment reported Resident #2 required extensive assistance from staff with one person physical assistance. He was 69 inches tall and weighed 144 pounds (#). He received a therapeutic and mechanically altered diet. An Occupational Therapy (OT) Evaluation and Plan of Treatment was completed on 5/6/22. The resident was referred to OT due to exacerbation of falls/fall risk, decrease in strength, decrease in functional mobility, reduced ADL participation, decreased neuromotor control and decreased coordination. An OT note dated 5/9/22 reported the resident completed self-feeding requiring minimum assistance and verbal cues. The note reported various adaptive equipment was tried to assist in promoting an increase in independence with self-feeding. An OT Evaluation and Plan of Treatment was again completed on 6/2/22. The OT note reported Resident #2 had presented with further decline with Activities of Daily Living (ADLs) and indicated he would benefit from OT services to improve range of motion (ROM), sitting balance and feeding tasks to decrease assistance from caregiver. An OT Treatment Encounter Note dated 6/3/22 reported the resident completed a self-feeding task during breakfast requiring minimum to moderate assist with verbal cues. He was reported as able to assist with feeding of finger foods with stand by assistance. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation was conducted on 6/9/22 at 8:43 AM and a resident interview attempted. Resident #2 was observed lying in his bed with the head of the bed raised and his bedside tray table placed in front of him. An 8-ounce empty glass with an orange liquid appearing at the bottom of the glass was observed to be on his tray table in front of him. His breakfast meal tray had been removed from the room and placed on the high boy cart in the hallway outside of his room. Resident #2's meal tray was observed as having regular utensils on it with his fork lying on the plate under the insulated dome. No curved, weighted utensils were on Resident #2 ' s meal tray. The plate included 1 slice bread (75% uneaten), eggs (none eaten), grits (none eaten). Resident #2's meal ticket on the tray included a notation which read in part, Adaptive Equipment: Weighted Knife, Weighted Spoon, Weighted Fork. Note: Curved Weighted Utensils. An interview was conducted on 6/9/22 at 2:20 PM with the Dietary Manager. During the interview, the Dietary Manager was informed of the observation of Resident #2's breakfast meal tray missing his built-up utensils. The Dietary Manager stated the adaptive equipment printed on the meal ticket was what should be sent on the meal tray for the resident. However, she questioned whether the built-up utensils would be helpful for the resident. An interview was conducted on 6/13/22 at 9:55 AM with the facility's Director of Rehab. The Director of Rehab was also a Certified Occupational Therapy Assistant (COTA) who was familiar with Resident #2 and had worked with him. The Director reported at this time, the resident required built up utensils for self-feeding, along with supervision throughout the meal. When asked, she reported the resident could do fairly well with self-feeding using the built-up utensils he had. However, if he dropped the utensil, he would not be able to pick it back up. Upon further inquiry, the Director of Rehab reported it would be okay for the resident to be eating on his own without a staff member continually in the room; however, the staff member would need to check back with him to see if he needed help and/or to be fed the meal. An observation was conducted on 6/13/22 at 12:20 PM of Resident #2 as he was lying in bed with his head of the bed raised and his lunch meal tray placed on the bedside tray table in front of him. He had a built-up spoon and fork on the tray and was observed to be using the built-up spoon to be feeding himself with his left hand. An interview was conducted with the facility's interim Administrator on 6/9/22 at 5:45 PM. During the interview, concerns were expressed regarding failure of Resident #11 to have built-up utensils available during a mealtime observation. The interim Administrator stated he would expect the built-up utensils to be on his meal tray for each meal and provided additional staff assistance if he had difficulty feeding himself.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41069 Based on record reviews, and interviews with staff, family member, Physician Assistant and Medical Director, the facility failed to provide effective leadership and implement effective systems to manage unintended weight loss, change in condition, physician notification and pressure ulcers. This failure affected 5 of 5 residents reviewed for administration (Resident #2, Resident #6, Resident #9, Resident #10, and Resident #11). Immediate Jeopardy began on 3/9/2022 when when effective systems were not in place to ensure residents received necessary care and services. Immediate Jeopardy was removed as of 6/18/2022 when the facility implemented an acceptable allegation of Immediate Jeopardy removal. The facility remains out of compliance at a scope and severity level E (No actual harm with potential for more than minimal harm that is not immediate jeopardy) for the facility to continue staff education and ensure monitoring systems put into place are effective. The findings included: This tag is cross referred to: F-580: Based on record reviews, and interviews with staff, and Medical Director, the facility failed to notify the Primary Care Provider of significant changes in a resident's condition (Resident #9) when he developed a new opened sacral pressure ulcer, when the pressure ulcer deteriorated and when he continued to have hypotension (low blood pressure) despite receiving intravenous fluids. The facility also failed to report results of a urinalysis and urine culture resulting in a delay in treating the resident (Resident #9) for UTI (urinary tract infection). Resident #9 was hospitalized on [DATE] for severe sepsis/septic shock due to an infected stage 4 pressure ulcer to the sacrum. In addition, the facility failed to notify the Primary Care Provider when a resident had a severe unintended weight loss (Resident #10). Resident #10 had a cumulative weight loss of 24.4% from 1/19/22 through 4/6/22, was admitted to the hospital on 4/7/22 and had a feeding tube inserted in the stomach. These failures were for 2 of 3 residents reviewed for notification of changes (Resident #9 and Resident #10). F-684: Based on record reviews, and interviews with staff, family member, Physician Assistant and Medical Director, the facility failed to identify the seriousness of significant changes in a resident's condition (Resident #9), complete and document on-going thorough assessments and identify the need for medical attention when the resident's medical condition continued to deteriorate. This resulted in a delayed treatment for UTI (urinary tract infection) and hospitalization for sepsis due to an infected stage 4 pressure ulcer. This failure was for 1 of 3 residents reviewed for quality of care (Resident #9). (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	F-686: Based on observations, record reviews, and interviews with staff, Wound Physician, Physician Assistant, and Medical Director, the facility failed to complete skin assessments as ordered, effectively assess, and monitor a pressure ulcer, and ensure treatments/interventions were implemented and modified/adjusted according to resident's response (Resident #9). Resident #9 who was at high risk for pressure ulcers was hospitalized on [DATE] with an infected stage 4 pressure ulcer (full-thickness skin and tissue loss) with tunneling (passageway of tissue destruction under the skin surface). In addition, the facility failed to update physician orders on a resident's Treatment Administration Record (TAR) to match the wound dressing orders in the Wound Physician notes for wound dressings (Resident #6). These failures were for 2 or 3 residents reviewed for pressure ulcers (Resident #9 and Resident #6). F-692: Based on staff interviews and record reviews, the facility failed to monitor a resident's weight on a weekly basis as ordered by the physician, identify a severe unintended decline in his weight, and implement/adjust interventions. The resident was sent to the hospital on 4/7/2022 and had a feeding tube placed in the stomach for 1 of 1 resident (Resident #10) reviewed for maintain nutritional status. The facility also failed to provide a physician ordered nutritional supplement for 2 of 2 sample residents (Resident #11 and Resident #2). An interview conducted with the Administrator and the Corporate Nurse Consultant on 6/15/22 at 2:09 PM revealed they were not aware of the severity of the wounds and weight loss experienced by the affected residents, and the former Director of Nursing and the former Administrator played an enormous part in the issue. They stated they needed to put effective systems in place, so the same issues don't happen again in the future. The Administrator was notified of Immediate Jeopardy on 6/15/22 at 1:28 PM. The facility provided the following IJ Removal Plan with the correction date of 6/18/22. All the following was covered with the New Administrator and Director of Nursing. * Nurse Consultant will be providing facility oversight to the administrative staff to ensure that action plans are being followed. * Nurse Consultant re-educated the Administrator and Director of Nursing on job descriptions with emphasis on the role and responsibilities in the oversight of resident care and services on 6/17/22. * Nurse Consultant re-educated the Administrator and Director of Nursing on regulation F-835 with emphasis on the role and responsibilities in the oversight of resident care and services on 6/17/22. * Nurse Consultant reviewed the role and responsibilities related to Quality Assurance with the Nursing Home Administrator and Director of Nursing. * Nurse Consultant re-educated the Administrator and Director of Nursing related to the findings outlined in the Immediate Jeopardy deficiencies to include corrective plan and ongoing process evaluation and monitoring. * Systematic changes: (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	* Implemented daily clinical meeting to discuss weights, labs, pressure ulcers and change of conditions. * Implemented weekly resident risk meeting to discuss areas such as weight loss, critical labs, pressure ulcers and weight loss. * Implemented additional shift to shift communication collaterals related to acute changes in condition, high-risk events, and labs. * New Administrator and Director of Nursing have been introduced to employees during the process of education related to the corrective actions taken by the facility on the immediate jeopardies. * Decision was made on June 17th, 2022, to hold a Resident council meeting to introduce the administrative staff and expectations of care and staff moving forward. Quality Assurance/Performance Improvement On 6/17/22, an Ad hoc Quality Assurance Performance Improvement (QAPI) Meeting was convened to review the Credible Allegation of Compliance as written. All plans that have been put in place are effective and we respectfully request the removal of Immediate Jeopardy status as of 12:00 AM on 6/18/22. * The Corporate Nurse Consultant educated the Administrator and DON on the components of the regulations completed. Additionally, the systems and processes were reviewed for all deficient practices and were updated on 6/13/22 pertaining to: *F580 Notify of Changes *F684 Quality of Care *F686 Treatment/Services to Prevent/Heal Pressure Ulcers *F692 Nutrition/Hydration Status The Administrator is responsible for ensuring that the Focus Meetings are being held and the Administrator was informed of this responsibility on 6/15/22. * The facility will conduct weekly Focus meetings with the Interdisciplinary team to discuss any resident weight losses, skin integrity issues, and any abnormal labs. or any issues with morning reviews of lab. book to determine if any trends and will discuss the interventions put in place; skin assessments, wound measurements with wound healing progress or issues with wound healing; and lab. issues noted in morning reviewed by the DON or DON Designee. If interventions are not reflective of achieving desired results, the Primary Care Provider will be notified, and interventions will be re-addressed and potential to add or eliminate and replace interventions as appropriate to achieve wound healing goals; weight gain goals; notification of labs. and change of conditions. Date of alleged IJ removal - 6/18/22 (continued on next page)

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	345307	A. Building B. Wing	06/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Ivy at Gastonia LLC	4414 Wilkinson Blvd Gastonia, NC 28056

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The credible allegation for the immediate jeopardy removal was validated on 6/23/22 with a removal date of 6/18/22. On 6/17/22 at the daily clinical meeting, all areas of the immediate jeopardy citations were reviewed with the interdisciplinary team (IDT) and interventions put into place were discussed. This was validated by interviews with members of the IDT. A weekly focus meeting was held on 6/17/22 which included the Administrator, the Director of Nursing, and the Infection Preventionist. They discussed the following areas: skin observations, wound reports, laboratory audit review/notification, weight loss, change of conditions and acute charting boards. A review of the resident council meeting minute dated 6/22/22 indicated the new Administrator and Director of Nursing introduced themselves to the residents and reviewed with them their care expectations. The audit tools completed by the facility on skin status, laboratory results and weights were reviewed. The medical provider was notified of results from the audits for additional follow-up as needed. On 6/17/22, the Corporate Nurse Consultant provided education with the new Administrator and Director of Nursing on their job descriptions, roles, and responsibilities in the oversight of resident care and services. They were also educated on identifying issues with immediate jeopardy cited and discussed with them the components of the regulations for F-580, F-684, F-686, F-692 and F-835. The education also included QA roles and responsibilities, correction plans and monitoring processes. Interviews with nurses and nurse aides revealed they received education on identifying any changes in resident condition including skin issues, weight loss, changes in vital signs and daily habits and reporting these changes to the nurses and the medical providers.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 43332 Based on record review and staff interviews, the facility failed to maintain accurate documentation on the Treatment Administration Record (TAR) for wound care to pressure ulcers and a peg tube insertion site for 1 of 2 residents (Resident #6) reviewed for wound care. The findings included: Resident #6's physician orders active on 6/1/2022 showed the following wound treatment orders: - Left Lateral Ankle (1): Apply skin prep and foam dressing to left lateral ankle change every shower day (Monday and Thursday 7 A.M. - 7 P.M.). Order was discontinued on 6/9/2022 at 12:54 P.M. - Left Lateral Ankle (2): Apply skin prep then cover with foam and bordered gauze on shower days on day shift on Monday, Thursday and Saturday. Order was discontinued on 6/9/2022 at 8:07 P.M. - Left Lateral Ankle (3): cleanse with 0.125 % Sodium Hypochlorite solution. apply wet to moist 0.125% Sodium Hypochlorite saturated gauze to wound bed then cover with superabsorbent dressing and wrap with kerlix. Change daily on day shift. Order was discontinued on 6/9/2022 at 12:48 P.M. - Peg (feeding tube inserted into the stomach) tube insertion site: cleanse with 0.125% sodium hypochlorite solution, apply silver alginate, and split gauze. Changed daily on day shift. Order was discontinued on 6/9/2022 at 12:52 P.M. - Right Hip (1): wound cleanser, then apply collagenase ointment to wound bed and apply calcium alginate with silver. Cover with superabsorbent dressing and bordered gauze. Change daily on day shift for pressure ulcer to right hip. Order was discontinued on 6/9/2022 at 12:52 P.M. -Right Hip (2): cleanse with wound cleanser then apply collagenase ointment to wound bed and apply calcium alginate with silver. Cover with superabsorbent dressing and bordered gauze. Change daily on day shift for pressure ulcer to right hip. Order was discontinued on 6/9/2022 at 12:51 P.M. - Left Hip: cleanse with 0.125% sodium hypochlorite solution then apply wet to moist 0.125% sodium hypochlorite solution saturated gauze to wound bed then cover with superabsorbent dressing and wrap with rolled gauze, change daily. Order was discontinued on 6/9/2022 at 7:54 P.M. - Right Ankle: wash skin, skin prep daily; Apply foam dressing three times a week during day shift on Sunday, Tuesday, and Thursday: Order was discontinued on 6/9/2022 at 12:50 P.M - Sacrum (buttocks): Apply hydrocolloid dressing change three times a week on Sunday, Tuesday and Thursday during day shift. Resident #6's Treatment Administration Record (TAR) reviewed for 6/1/2022 through 6/9/2022 indicated the following treatments were not documented as completed or not completed: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Left Lateral Ankle (1): Not documented on Thursday, 6/2/2022 and Thursday, 6/9/2022 - Left Lateral Ankle (2): Not documented on Thursday, 6/2/2022; Saturday 6/4/2022, and Thursday, 6/9/2022 - Left Lateral Ankle (3): Not documented on Thursday, 6/2/2022; Saturday 6/4/2022, and Thursday, 6/9/2022 - Peg tube insertion site: Not documented on Thursday, 6/2/2022; Saturday 6/4/2022, and Thursday, 6/9/2022 - Right Hip (1): Not documented on Thursday, 6/2/2022; Saturday 6/4/2022, and Thursday, 6/9/2022 - Right Hip (2): Not documented on Thursday, 6/2/2022 and Thursday, 6/9/2022 - Left Hip: Not documented on Thursday, 6/2/2022; Saturday 6/4/2022, and Thursday, 6/9/2022 - Right Ankle: Not documented on Thursday, 6/2/2022 and Thursday, 6/9/2022 - Sacrum (Buttocks): Not documented on Thursday, 6/2/2022 and Thursday, 6/9/2022 A telephone interview was conducted on 6/13/2022 at 11:43 A.M. with the Unit Manager. The Unit Manager confirmed she completed Resident #6's dressing changes on 6/2/2022 and 6/9/2022 after the wound doctor evaluated Resident #6's wounds. During the interview, the Unit Manager stated she had not documented completed dressing changes on the TAR on the days she rounded with the wound doctor. She further stated all dressings changes should be documented on the TAR when they were completed. A telephone interview with Nurse #7 who was assigned Resident #6 on 6/4/2022 was attempted and was unsuccessful. Interviews conducted on 6/10/22 at 4:40 PM with the Director of Nursing #2 (DON) and the Regional Nurse Consultant revealed all dressing changes should be documented correctly on the TAR when the dressings were completed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 37280 Based on record reviews, observations, staff interviews and the high level of transmission for COVID-19 in the county, the facility failed to implement their infection control policy and the Centers for Disease Control and Prevention (CDC) guidelines for the use of Personal Protective Equipment (PPE) when 3 of 3 staff members (Nurse #2, Nurse #6 and the Interim Director of Nursing (IDON) failed to wear eye protection while providing care to 3 of 3 residents (Resident #2, Resident #15 and Resident #16) on 3 of 3 general halls. These failures occurred during a COVID-19 pandemic. The findings include: A review of the CDC COVID-19 Data Tracker on 06/13/22 indicated the county where the facility was located had a high level of community transmission for COVID-19. A review of the facility's policy for the use of Masks, Face Shields/Eye Goggles dated 06/2022 revealed the use of masks, face shields/eye goggles must be used by all staff only when the community transmission rate is high, or the facility is the highest level of cases per 100,000 people in the last 7 days according to CDC. The CDC guidance entitled, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated on 09/10/21 indicated the following information under the section Implement Universal Use of Personal Protective Equipment for HCP (Healthcare Personnel): If SARS-CoV-2 infection is not suspected in a patient presenting for care (based on symptom and exposure history), HCP working in facilities located in counties with substantial or high transmission should also use PPE (Personal Protective Equipment) as described below including: Eye protection (i.e., goggles or a face shield that covers the front and sides of the face should be worn during all patient care encounters. 1.a. On 06/13/22 at 2:51 PM through 3:02 PM a continuous observation was made of Nurse #4 going into Resident #2's room to medicate him. The Nurse wore a face mask but did not don eye protection before going into the Resident's room and encountering the Resident. b. On 06/13/22 at 3:05 PM through 3:14 PM a continuous observation was made of Nurse #4 going into Resident #15's room to assess his urinary suprapubic catheter by releasing his brief to inspect his suprapubic site. The Nurse wore a face mask but did not don eye protection before going into the Resident's room and encountering the Resident. An interview was conducted with Nurse #4 on 06/13/22 at 3:14 PM who explained that she had only been employed at the facility for about 90 days and had received education on infection control upon hire but since that time there had not been consistent leadership in the infection control area. The Nurse continued to explain that as far as she knew she did not have to wear eye protection because they only had to wear eye protection when taking care of residents with COVID and there was no COVID in the facility. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. On 06/13/22 from 3:20 PM to 3:35 PM a continuous observation was made of Nurse #6 entering Resident #16's room to provide dressing changes on Resident #16's feet. During the encounter at 3:21 PM the Interim Director of Nursing (IDON) entered the Resident's room to assist Nurse #6 with the treatment. Neither the Nurse nor the IDON donned personal eye protection before engaging in the Resident care encounter. On 06/13/22 at 3:35 PM interviews were conducted with both the Interim Director of Nursing and Nurse #6 immediately after the encounter with Resident #16. The IDON explained that she was part time and did not work with Resident #16 on a consistent basis and Nurse #6 explained that today (06/13/22) was her first day of employment at the facility. Both nurses continued to explain that they were under the impression that they did not have to wear protective eye if the resident was not COVID positive. The nurses stated they were not aware of what the county transmission level was and had not been educated by the facility to wear eye protection. An interview was conducted with Director of Nursing (DON) #2 and the Infection Preventionist (IP) on 06/13/22 at 4:20 PM. The DON stated that they both were hired on 06/07/22. The DON explained that she pulled information from the CDC website that indicated the community level for the county was medium which meant that the facility did not have to wear eye protection for resident encounters. The Surveyor informed the DON that the transmission level was what they should be going by which was high and indicated that personal eye protection should be worn for resident encounters. The DON and IP indicated they were unaware of the transmission level being the indicator and would immediately initiate wearing the eye protection. During an interview with both the Administrator and the Corporate Nurse Consultant (CNC) on 06/15/22 at 2:10 PM the Administrator stated she began her employment at the facility on 06/14/22. The CNC explained that she went by the community level which was medium and was not aware of the transmission level. The CNC continued to explain that the facility should be following the CDC guidelines for the use of Personal Protective Equipment.