STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. Building B. Wing	08/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saturn Nursing & Rehabilitation	1930 West Sugar Creek Road Charlotte, NC 28262

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37014 Based on record review and staff interviews, the facility failed to maintain accurate advanced directives throughout the medical record for 1 of 1 resident reviewed for advanced directives (Resident #65). Findings included: Resident #65 was admitted to the facility on [DATE] with multiple diagnoses that included Alzheimer's disease and dementia without behavioral disturbance. Resident #65's paper medical record revealed a Medical Orders for Scope of Treatment (MOST) form dated [DATE] that indicated her preference for a Do Not Resuscitate (DNR) status in the event she had no pulse and was not breathing. The form was signed by Resident #65's Responsible Party. The quarterly Minimum Data Set (MDS) dated [DATE] assessed Resident #65 with severe impairment in cognition. Resident #65's advanced directive care plan, initiated on [DATE], revealed her wishes would be honored relative to DNR code status. Resident #65's Electronic Medical Record (EMR), reviewed on [DATE] at 11:07 AM, revealed the following: On the profile page, Resident #65's code status was listed as Cardiopulmonary Resuscitation CPR (manual application of chest compressions and ventilation done when someone's breathing or heartbeat has stopped). Under Physicians Orders, there was a current order dated [DATE] that indicated Resident #65 had a code status of DNR. During an interview on [DATE] at 9:05 AM, Nurse #4 explained she referred to the current physician's orders in the resident's EMR when determining code status. Nurse #4 reviewed Resident #65's EMR and confirmed the code status of CPR on her profile page conflicted with the physician's order dated [DATE] which indicated she was a DNR. Nurse #4 added the code status on the profile page and physician's order should match. (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 10:02 AM, the Director of Nursing (DON) stated nursing staff were responsible for obtaining a resident's code status and entering the physician's order in the resident's EMR. The DON reviewed Resident #65's EMR and confirmed the code status of CPR on her profile page conflicted with the physician's order dated [DATE] which indicated she was a DNR. The DON stated both should match and the conflicting information related to code status could be detrimental in the event of an emergency. She added Resident #65's EMR should be updated to accurately reflect her wishes. During an interview on [DATE] at 10:35 AM, the Administrator stated Resident #65's code status listed in her paper medical record, physician's order and EMR should all match so in the event of an emergency, there would be no confusion and her wishes would be honored.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39037 Based on observations, record review, and interviews the facility failed: maintain the walls in resident rooms in good repair for resident rooms on 3 of 3 halls (rooms [ROOM NUMBER]); keep a toilet seat in good repair for 1 of 2 resident bathrooms (bathroom of room [ROOM NUMBER]); repair broken chairs in 1 of 1 dining room; ensure a baseboard was in place for 1 of 1 dining room wall; ensure a baseboard was in good repair for 1 of 1 resident room (room [ROOM NUMBER]); ensure drawers in a resident's built in chest was in good repair for 1 of 1 resident room (room [ROOM NUMBER]); ensure sanitary ceiling vents for 1 of 1 dining room; ensure a working overhead light was in place for 1 of 2 resident bathrooms (room [ROOM NUMBER]). The findings included: 1. An observation of room [ROOM NUMBER] on 08/02/21 at 08:40 AM revealed an exposed circular area of sheetrock to the wall beside A bed and multiple linear scratches with missing paint to the wall behind A bed. The corner of the wall near B bed's closet had exposed metal with peeling paint extending up to approximately 3/4 of the corner. The corner near the bathroom door had an area of detached partially unpainted metal that extended approximately 1/2 inch from the wall. A broken baseboard was observed to the wall beside the bathroom door. An observation or room [ROOM NUMBER] on 08/03/21 at 09:41 AM revealed the same conditions. 2. An observation of room [ROOM NUMBER] on 08/02/21 at 02:12 PM revealed an area of exposed sheetrock to the wall beside the entry door. The top drawer of the left side of the built in chest was missing. The bottom drawer of the chest built into the wall had broken wood to the front of the drawer. An observation of room [ROOM NUMBER] on 08/03/21 at 09:05 AM revealed the same conditions. An observation of room [ROOM NUMBER] on 08/04/21 at 11:48 AM revealed the same conditions. 3. An observation of the main dining room on 08/03/21 at 11:00 AM revealed 2 dining room chairs had both chair arms broken. The baseboard on the wall of the main dining room near the left kitchen door was observed to be missing. Three ceiling vents in the main dining room were observed to be covered with a black substance and a black substance was noted to be on the ceiling around the vents. 4. An observation of the bathroom of room [ROOM NUMBER] on 08/01/21 at 01:12 PM revealed a floor lamp sitting between the toilet and sink with the cord running under the sink and plugged into the wall. The overhead light in the bathroom was not working. A hole was noted to the bathroom wall across from the toilet that was the approximate length of the door handle. An observation of the bathroom of room [ROOM NUMBER] on 08/04/21 at 10:20 AM revealed the same conditions. 5. An observation of room [ROOM NUMBER] on 08/01/21 at 11:32 AM revealed peeling paint to the walls behind both beds. An observation of room [ROOM NUMBER] on 08/02/21 at 10:07 AM revealed the same conditions. 6. An observation of the bathroom of room [ROOM NUMBER] on 08/02/21 at 10:11 AM revealed the toilet seat was loose. An observation of the bathroom of room [ROOM NUMBER] on 08/04/21 at 10:20 AM revealed the same condition. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the Maintenance Director on 08/04/21 at 04:24 PM revealed he recently resigned his full-time position but agreed to work part-time until a full-time Maintenance Director could be hired. He explained before he stopped working full-time he placed a notebook at each nursing station where staff could document work orders but now there was a binder in a central location where staff could document work orders and he would prioritize the work orders. The Maintenance Director stated toilets, beds, call lights, and wheelchair repairs were his top priority. A follow-up interview with the Maintenance Director on 08/05/21 at 04:16 PM revealed he was responsible for changing light bulbs, fixing baseboards, fixing furniture in resident rooms, fixing toilet seats, and painting and patching repairs. He explained he did an environmental round weekly on 6-8 resident rooms and that ensured he was able to round on all rooms quarterly. The Maintenance Director stated he had a running list of items that needed to be painted or patched and someone was hired to work on but he resigned before the list was completed. A tour of the facility was completed with the Maintenance Director on 08/05/21 at 04:45 PM. The Maintenance Director stated he was not aware of the missing baseboard in the main dining room, was not aware of the broken chairs in the main dining, and he thought Housekeeping had a cleaning regimen for the ceiling vents. He stated he was aware of the peeling paint in room [ROOM NUMBER] and thought it was on the paint and patch list that did not get completed. The Maintenance Director stated he was not aware of the loose toilet seat in room [ROOM NUMBER] and he would be able to fix it today. He stated he was not aware of the exposed sheetrock, scrapes to the wall, missing baseboard, or metal corners being exposed in room [ROOM NUMBER]. The Maintenance Director stated he was not aware of the missing drawer on the built-in chest and the broken wood to the last drawer on the chest in room [ROOM NUMBER]. He stated the unpainted area on the wall in room [ROOM NUMBER] was on the paint and patch list that did not get completed by the former maintenance staff member. The Maintenance Director stated he was not aware of the overhead bathroom light not working or the hole in the wall behind the bathroom door in room [ROOM NUMBER] and he would replace the light bulb and add a plastic wall plate. The maintenance work order log was reviewed 08/05/21 at 05:00 PM and there was a notation on the 05/03/21-05/04/21 to patch the corner of room [ROOM NUMBER]. On the work order log for 05/03/21-05/04/21 a missing drawer was noted for room [ROOM NUMBER]. An interview with the Administrator on 08/05/21 at 06:00 PM revealed when the Maintenance Director was not present staff notified her of any maintenance issues. She explained if it was something she could handle she would address the issue. The Administrator stated the part-time maintenance staff member did not notify her of any maintenance concerns and she was not aware of the environmental concerns brought to the Maintenance Director's attention during the tour. She further stated the former part-time maintenance staff member would repair the paint in visible areas and would take his paint trolley into resident rooms, close the door, and give the illusion he was painting but did not complete the work. An interview with the Housekeeping Supervisor on 08/05/21 at 06:46 PM revealed housekeeping was responsible for cleaning the ceiling vents and they were cleaned daily. She explained the vents could be cleaned and then in 15 minutes they did not look like they had been cleaned. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the former part-time maintenance staff member on 08/06/21 at 11:35 AM revealed he worked at the facility for 60-70 days. He explained he was hired to assist the Maintenance Director fix plaster and paint walls. The former staff member stated he received a paint and patch list from the Maintenance Director and then if other maintenance concerns arose the Maintenance Director told him what to do. He explained that system worked fine as long as the Maintenance Director was there on a daily basis but if he did not work the former staff member was unsure of what needed to be done.

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F 0602 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37538 Based on record review and resident, staff, and the responding Police Officer interviews, the facility staff failed to report a resident kept a large sum of money on his person which put him at high risk for abuse, exploitation, and misappropriation and failed to prevent misappropriation of resident property when the money was removed from his pant pocket and stolen by an individual for 1 of 5 residents reviewed for abuse (Resident #98). The findings included: Resident #98 was admitted to the facility on [DATE] with diagnoses including incomplete paralysis of all four limbs and spasticity (condition in which muscles stiffen or tighten preventing normal movement). Resident #98 was listed as his own Responsible Party on the face sheet of his medical record and the first Power of Attorney (POA) listed on his advance directive. The quarterly Minimum Data Set (MDS) dated [DATE] assessed Resident #98 as being cognitively intact. Assistance needed for activities of daily living was assessed as requiring total assistance bed mobility, transfers, eating, and toilet use. There was no upper extremity range of motion impairment and impairment on both side of the lower extremities. Review of the 24-hour report revealed on 6/6/21 at 4:45 PM the facility became aware Resident #98 reported his money was stolen. The Police Department was notified, and an investigation started. Resident #98 was interviewed on 8/2/21 at 8:51 AM. Resident #98 revealed his named second POA had brought $9000.00 in cash to the facility upon his request. Resident #98 explained he was expecting to move out of the facility and after paying rent on a house he had $7200.00 left. Resident #98 kept the money in a double knotted sock. During the day the sock stayed in his pant pocket and at bedtime he asked Nurse Aide (NA) staff to put the sock in the pillowcase of the pillow he slept on. Resident #98 stated he didn't tell the Administrator about keeping a large amount of money because he preferred to keep his money close to him. Resident #98 explained the money was stolen from him on 6/6/21 by a male dressed in black scrubs who claimed he worked for the nursing agency the facility used. Resident #98 stated the male was able to locate him in the smoking area and appeared to know he had money in his pant pocket and removed the sock from his pocket then left the facility. Resident #98 revealed he identified the suspect on NA #4's social media. The male was somehow related to NA #4 and NA #5 and arrested by the police. Resident #98 provided the name of a resident who witnessed the theft and of NA staff who had seen or who he thought knew about the money in the sock. Resident #98 stated he experienced post-traumatic stress from the incident and didn't feel safe in the building and felt Administration didn't care and hadn't done anything about the incident. (continued on next page)

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F 0602 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted on 8/05/21 at 11:33 AM with Nurse #12. Nurse #12 was the designated receptionist on 6/6/21 when a male she didn't recognize entered from the front door. She buzzed him in, and he told her he was from agency and gave his name. Nurse #12 checked the schedule kept at the front desk stating his name wasn't on it and that was not unusual, and the schedule frequently changed due to call outs. The male was wearing scrubs and no badge. The male said he was working on the south unit, so she gave him directions and he proceed that way. When the male came back, he was pushing the door and said he needed to go out to his car. She buzzed the door open for him and he exited the facility to the parking lot. Resident #98 was coming up the hallway saying something, but Nurse #12 couldn't hear what until he got to the front desk and stated that guy robbed me. The police were called and she thought Resident #98 told her it was around $7000.00 that was stolen. Nurse #12 stated she wasn't aware Resident #98 had a large amount of money on his person. Now agency staff must wear a badge and provide their ID and those were scanned and kept in a log book at the front desk along with the schedule to verify they are agency assigned to work. The person at front desk makes copies of agency staff IDs and dates the copy and places in the logbook. Review of the progress note written by the Social Worker on 6/18/21 revealed after meeting with his caseworker Resident #98 requested to receive psychotherapy services and an order was requested. A psychotherapy note dated 7/29/21 revealed Resident #98 reported he didn't want to participate in psychotherapy. The note read in part, today is his 3rd week in a row he has declined psychotherapy and was assessed if he wanted to continue services or would like to discharge. He reports doing well and wants to discharge from psychotherapy. An interview was conducted with the person listed as the second POA on 8/06/21 at 11:57 AM. The POA confirmed she brought $10,000.00 in cash and gave the money to Resident #98. The POA didn't recall the exact date the money was brought to the facility and explained Resident #98 wanted the money because he had expected to be discharged , so she brought the money to the facility. The POA didn't tell anyone about bringing the money to the facility. After the robbery Resident #98 told the POA he was robbed approximately 20 to 30 minutes after asking NA #4 to put the sock of money in his pant pocket. An interview was conducted on 8/10/21 at 9:45 AM with NA #2. NA #2 previously worked 2nd shift at the facility and had provided care to Resident #98 but wasn't there the day of the robbery. NA #2 revealed she counted the money when it was first brought to the facility and stated there was $9000.00 in cash. On the day NA #2 counted the money she placed the stack of money in plastic bag and put the bag in a knotted sock then in the pocket of Resident #98's pants. Afterwards when NA #2 assisted Resident #98 out of bed she would remove the sock from his pillowcase and place the money in his pant pocket. NA #2 didn't share with anyone else Resident #98 had $9000.00 in cash and stated, I told no one. NA #2 revealed there were 2 other NA staff who also knew about Resident #98's money but couldn't recall their names. NA #2 explained she didn't tell anyone about the money and Resident #98 was able to make his own decisions and she did not recall when it was brought to the facility or when she counted it. (continued on next page)

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F 0602 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted with NA #4 on 8/10/21 at 4:34 PM. NA #4 revealed she and NA #5 (a family member) both worked for the staffing agency the facility used and 6/6/21 was her second day at the facility and first day caring for Resident #98. NA #4 explained on 6/6/21 around lunch time she and NA #5 used a mechanical lift to provide total assistance getting Resident #98 out of bed. Resident #98 asked NA #4 to reach under his pillow for a sock and place it inside his pant pocket. NA #4 stated she could tell there was something in the sock but couldn't see what and Resident #98 didn't tell her. NA #4 revealed Resident #98 was fed lunch by NA #5 who needed total assistance with eating and couldn't feed himself. NA #4 revealed she had not heard about any money until after the robbery and she repeated several times others knew about the money. Multiple attempts to interview NA #5 were unsuccessful. An interview was conducted on 8/09/21 at 4:31 PM with NA #11. NA #11 revealed Resident #98 told her he had $7000.00 before the incident happened and that he kept in a sock he tied in a knot. NA #11 revealed she didn't see the money but did see the sock and stated she could tell it was a large sum of money by the shape and described it looked like a big stack of money. Resident #98 would have NA #11 put the sock of money in his nightstand drawer which he had a key to lock. NA #11 would lock the drawer and put the key in container kept on top of the nightstand. When NA #11 would get Resident #98 out of bed he asked her to get his money out of the locked drawer and put it in his pocket. NA #11 revealed she didn't question the fact Resident #98 kept a large sum of money in his room and on his person stating he was of sound mind. An interview was conducted on 8/10/21 at 5:13 PM with NA #3. NA #3 revealed she had provided care for Resident #98 but wasn't told about the money. When NA #3 put Resident #98 to bed, he asked her to remove the sock from his pant pocket and place it in the pillowcase of the pillow behind his head. NA #3 revealed the sock appeared thick and she could tell it was money by the way it felt and by how protective and close Resident #98 kept the sock to his person. NA #3 revealed she started seeing the sock sometime in May but was unsure of exactly when and stated he didn't have it long. NA #3 explained when Resident #98's plans to discharge from the facility changed that was when she recalled seeing the sock. NA #3 didn't discuss this with anyone at or outside the facility. An interview was conducted on 8/12/21 at 1:42 PM with NA #6. NA #6 revealed she had seen Resident #98's money, which appeared to be a lot, but didn't know how much cash there actually was. NA #6 described Resident #98 had several stacks of money separated and banded together that were kept in a knotted sock. NA #6 explained at night whoever put Resident #98 to bed would place the sock in his pillowcase and whoever got him up would put the sock in his pant pocket. NA #6 stated she should have told someone about seeing that much money on a resident but felt like the Administrator or a Supervisor knew because Resident #98 was ready to leave the facility and in process of getting his own apartment. The Police Officer (PO) who responded to the robbery was interviewed on 8/11/21 at 3:29 PM. The PO revealed the suspect was able to gain access to Resident #98 after being let in the facility by giving a false name and stating he worked for the nursing agency used by the facility. Resident #98 identified the suspect on NA #4's social media who was also related to NA #4 and NA #5. The suspect was brought in for an ID line up, Resident #98 identified him as the perpetrator, and an arrest was made. (continued on next page)

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F 0602 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted on 8/03/21 at 1:17 PM with the Administrator. The Administrator revealed NA #4 and NA #5 both worked for the agency company used by the facility and had worked the day of incident. The Administrator was unable to get an interview from either one. NA #4 called the facility on 6/7/21 and began screaming at the Administrator stating she and NA #5 had not stolen any money. The Administrator called the agency company and requested neither NA #4 nor NA #5 return to the facility. A follow up interview was conducted on 8/11/21 at 11:47 AM with the Administrator. The Administrator explained Resident #98 felt like someone from the facility had tipped off the robber but was unsure who. After her 5- day investigation Resident #98 did share with her he thought NA#4 and NA #5 had tipped someone off because they were the 2 newest staff. The Administrator explained Resident #98 shared with her that other staff members at the facility were aware he had money, but he didn't think they knew how much and didn't name anyone who had counted or seen his money. After the incident, employees were trained, and her in-service included educating staff to report to her or the Social Worker (SW) when they see a resident with a lot of money. Either her or the SW would meet with the resident and ask if they would like to put the money in the business office safe or lock in their nightstand and also educated not to show the money to others if they chose not to put in the safe. An interview was conducted on 8/12/21 at 10:19 AM with the Administrator. The Administrator revealed the staff she interviewed thought Resident #98 had money but didn't know how much and no one ever reported anything to her. The Administrator stated if NA #2 counted $9000.00 in cash for Resident #98 she hoped NA #2 would report that to her even though Resident #98 was able to make his own decisions. The Administrator stated if any of the NA staff had informed her Resident #98 had a large amount of money he was keeping at the facility, she would've told him the money needed to be locked up in the safe. In addition, if Resident #98's second POA would've informed her she brought a large sum of money to the facility, she would've told the POA to take it back. The Administrator confirmed when NA#2 counted Resident #98's money and allowed him to keep a large sum of money on his person, he was put at risk for misappropriation of property.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43443 Based on record review and staff interviews, the facility failed to complete the Minimum Data Set (MDS) within 14 days of a resident's admission for 1 of 3 sampled residents (Resident #410). Findings Included: Resident #410 was admitted to the facility on [DATE]with a diagnosis of necrotizing (death of tissue) soft tissue infection of the sacrum. Resident #410's admission Minimum Data Set assessment dated [DATE] revealed the MDS was in progress. The MDS was due to be completed on 8/2/21 and on 8/11/21 it was not completed. During an interview by phone with MDS Nurse #1 on 8/11/21 at 11:10 AM stated she knew Resident #410's MDS was late but she could not help it. She stated she had been out of work most of the month of July. In an interview on 08/11/21at 11:42 AM with the DON and the Administrator they verified that MDS Nurse #1 had been out of work most of July 2021. They stated they just hired a new MDS nurse, but she had only been working a few days. They stated it was their expectation that Minimum Data Set assessments be completed according to the federal regulations and company policy regarding completion and timing.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43222 Based on staff interviews and record review the facility failed to identify a resident with significant changes in status and failed to complete a significant change in status Minimum Data Set (MDS) assessment for 1 of 2 residents reviewed for decline (Resident #54). Findings included: Resident #54's active diagnosis included: Dementia, Alzheimer's, and Failure to Thrive. Review of the admission MDS dated [DATE] revealed Resident #54 required limited assistance of 1 staff for transfers and toileting. She required extensive assistance of 1 staff for bed mobility. A review of the quarterly MDS dated [DATE] revealed Resident #54 required total dependence of 1 staff for bed mobility and toileting, while transfer activity did not occur. An interview was conducted with Nurse Aide #6 on 8/3/21 at 9:21 am. She stated Resident #54 was totally dependent on staff with activities of daily living (ADL) prior to February 2021. The MDS Nurse #1 was interviewed on 8/2/21 at 3:37 pm. She stated if a resident had a decline in 2 or more areas of ADL then a significant change in status assessment should be completed. The MDS nurse stated Resident #54's ADL decline from February to May would have indicated a significant change assessment. She stated MDS Nurse #2 completed the MDS assessment for Resident #54 in May 2021. An interview conducted with the MDS Nurse #2 on 8/4/21 at 10:42 am revealed she did not complete a significant change assessment for Resident #54 because she did not have an actual, physical decline from she was admitted . The MDS Coordinator #2 stated when looking at ADL coding sheets, Resident #54 had several incidents of total dependence from February to May 2021. She indicated a significant change assessment was performed when a decline/improvement occurred in at least 2 late loss ADL. During an interview with the Director of Nursing (DON) on 8/4/21 at 8:29 am, she stated Resident #54's ADL decline from February to May of 2021 would have warranted a significant change assessment. The DON stated the assessment was not completed due to staffing issues and not having a full-time MDS Nurse available. An interview conducted on 8/5/21 at 9:02 am with the Administrator revealed a significant change assessment should have been performed after Resident #54's ADL decline was observed. She stated she was not sure why it was not completed.

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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** 37014 Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessments in the areas of Preadmission Screening and Resident Review (PASRR), falls and date of death for 3 of 7 sampled residents reviewed for PASRR, accidents and closed record review (Residents #38, #70 and #111). Findings included: 1. Resident #38 was admitted to the facility on [DATE] with diagnoses that included bipolar disorder. Review of a PASRR Level II Determination Notification letter dated [DATE] revealed Resident #38 had a time-limited Level II PASRR with an expiration date of [DATE]. The admission Minimum Data Set (MDS) dated [DATE] indicated that Resident #38 had not been evaluated by Level II PASRR and determined to have a serious mental illness and/or intellectual disability. During a telephone interview on [DATE] at 1:04 PM, MDS Nurse #1 explained the SW notified her via email of any resident with a Level II PASRR for coding the MDS assessments. MDS Nurse #1 explained if she did not receive an email from the SW regarding a resident's Level II PASRR status, then it was assumed the resident was a Level I PASRR and the MDS was coded accordingly. MDS Nurse #1 could not recall if she had been notified by the SW that Resident #38 had a Level II PASARR effective [DATE]. She added the admission MDS dated [DATE] for Resident #38 was coded incorrectly and a modification would need to be submitted to accurately reflect she had a Level II PASRR. During an interview on [DATE] at 9:49 AM, the Social Worker (SW) explained she kept track of residents with a Level II PASRR and notified the MDS Nurses for them to be aware to code it on the MDS assessments. The SW added she had somehow overlooked Resident #38's Level II PASRR when she was admitted to the facility and therefore, the MDS Nurse was not notified. During an interview on [DATE] at 5:30 PM, the Administrator stated her expectations were for MDS assessments to be accurately coded and explained due to human error, Resident #38's Level II PASRR had been entered incorrectly in the system as a Level I PASRR and as a result, her admission MDS assessment dated [DATE] was incorrectly coded. 2. Resident #70 was admitted to the facility on [DATE] with multiple diagnoses that included an autoimmune disease that affects the central nervous system. Review of a nurse progress note dated [DATE] read in part, Resident #70 slid out of the wheelchair during transport in the facility van with minor injury to his leg that was treated with topical antibiotic ointment and covered with a dry dressing. No other injuries were noted. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the x-ray results dated [DATE] revealed Resident #70 had a mildly displaced oblique (slanting) fracture of the distal tibia (inner bone between the knee and ankle) and nondisplaced (bone is broken but not out of alignment) fracture of the distal fibula (outer bone between the knee and ankle). The quarterly Minimum Data Set (MDS) dated [DATE] noted Resident #70 had one fall with no major injury since the prior MDS assessment dated [DATE]. During a telephone interview on [DATE], MDS Nurse #1 explained she did not have time to review documentation in a resident's medical record, such as nurse progress notes or x-ray results, when completing MDS assessments and coded falls/injuries based off the incident reports completed by the nurse. MDS Nurse #1 was unable to access the incident report for Resident #70 but stated she was aware that he had sustained a fracture related to his fall on [DATE] and the quarterly MDS dated [DATE] should have been coded to reflect he had a fall with major injury. She added a modification would need to be submitted. During an interview on [DATE] at 5:30 PM, the Administrator stated her expectations were for MDS assessments to be accurately coded and the MDS assessment dated [DATE] should have been coded to reflect Resident #70 had a fall with major injury due to his diagnoses of leg fracture. 3. Resident #111 was admitted to the facility on [DATE] with multiple diagnoses that included End-stage Renal Disease (ESRD). The death in the facility Minimum Data Set (MDS) for Resident #111 completed and submitted on [DATE] noted an assessment reference date of [DATE]. The MDS further noted a discharge date of [DATE] and listed Resident #70's discharge status as deceased . Review of a nurse progress note dated [DATE] read in part, Resident #111 was found unresponsive with fixed and dilated pupils, no pulse and not breathing. Time of death verified at 1:30 AM. During a telephone interview on [DATE] at 1:04 PM, MDS Nurse #1 explained she received a daily census report from the business office noting any death in the facility. MDS Nurse #1 stated she completed the death in facility MDS assessment based off the information listed on the daily census report and did not review nurse progress notes in the resident's medical record to clarify the actual date of death . She added a modification would need to be submitted to accurately reflect Resident #111's date of death as [DATE]. During an interview on [DATE] at 5:30 PM, the Administrator confirmed Resident #111 passed away at the facility on [DATE] and stated the MDS assessment should have been accurately coded to reflect the correct date of his death.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37014 Based on record review and staff interviews, the facility failed to request a Preadmission Screening and Resident Review (PASRR) before the expiration date for 1 of 1 resident reviewed with a Level II PASRR (Resident #38). Findings included: Resident #38 was admitted to the facility on [DATE] with diagnoses that included bipolar disorder. The admission Minimum Data Set (MDS) dated [DATE] indicated that Resident #38 had not been evaluated by Level II PASRR and determined to have a serious mental illness and/or intellectual disability. Review of a PASRR Level II Determination Notification letter dated [DATE] noted Resident #38 was evaluated and assigned a time-limited Level II PASRR with an expiration date of [DATE]. Further review revealed in part, if Resident #38's nursing facility placement was expected to extend beyond the expiration date, the nursing facility was responsible for initiating further screening through the Level II evaluation process within 5 calendar days of the PASRR expiration date. During an interview on [DATE] at 9:49 AM, the Social Worker (SW) confirmed she was responsible for initiating and coordinating Level II PASRR reviews. The SW explained she kept resident PASRR Notification Letters in a notebook and flagged the ones with expiration dates as a reminder for her to follow-up on before the PASRR expired. The SW stated Resident #38's Level II PASRR was somehow overlooked upon her admission and therefore, a request for a Level II PASRR screening was not submitted and Resident #38's PASRR expired on [DATE]. During an interview on [DATE] at 10:35 AM, the Administrator explained the SW was responsible for keeping track of residents who had Level II PASRR and requesting PASRR screenings when needed and prior to the expiration date, if applicable. The Administrator confirmed she was made aware that Resident #38's Level II PASRR had expired on [DATE] and explained it was overlooked due to human error.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37014 Based on record review and staff interviews, the facility failed to develop comprehensive, individualized care plans that addressed the areas of Preadmission Screening and Resident Review (PASRR), smoking and actual pressure ulcers for 3 of 6 sampled residents reviewed for PASRR, accidents and pressure ulcer/injury (Resident #38, #17 and #44). Findings included: 1. Resident #38 was admitted to the facility on [DATE] with diagnoses that included bipolar disorder. Review of a PASRR Level II Determination Notification letter for Resident #38 and dated 01/25/21 revealed nursing facility placement was appropriate for a 90-day period with specialized services that consisted of psychiatric services provided by a Psychiatrist and rehabilitative services. The admission Minimum Data Set (MDS) dated [DATE] indicated that Resident #38 had not been evaluated by Level II PASRR and determined to have a serious mental illness and/or intellectual disability. Review of Resident #35's active care plans, last reviewed/revised 07/05/21, revealed no care plan that addressed her Level II PASRR status or the specialized services needed as described in the PASRR Level II Determination Notification. During interviews on 08/03/21 at 9:49 AM and 08/09/21 at 2:58 PM, the Social Worker (SW) explained she kept track of all residents with a Level II PASRR and was responsible for developing a PASRR care plan. The SW added she had somehow overlooked Resident #38's Level II PASRR when she was admitted to the facility and therefore, a care plan was not developed. During an interview on 08/05/21 at 5:30 PM, the Administrator explained due to human error, Resident #38's Level II PASRR had been entered incorrectly in the system as a Level I PASRR and as a result, a care plan was not developed but should have been. 39037 2. Resident #17 was admitted to the facility 01/05/19 with diagnoses including traumatic spinal cord dysfunction and gastroesophageal reflux disease (GERD). A document titled Care Plan Detail dated 06/08/20 stated Resident #17 chose to smoke cigarettes. No goals or interventions were present on the document. Review of the annual Minimum Data Set (MDS) dated [DATE] revealed Resident #17 was cognitively intact and used tobacco. A Safe Smoking Evaluation was performed 07/27/21 and Resident #17 was deemed to be a safe smoker. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the Administrator on 08/05/21 at 06:15 PM confirmed there was not a completed care plan for smoking for Resident #17 and there should be a care plan for smoking present in Resident #17's chart. The Administrator stated MDS nurses were responsible for developing care plans. An interview with MDS Nurse #1 on 08/10/21 at 04:06 PM revealed she would have been the person responsible for completing the smoking care plan for Resident #17 and it just got missed. 3. Resident #44 was admitted to the facility 01/22/21 with diagnoses including seizure disorder and respiratory failure. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #44 was severely cognitively impaired and had 2 stage 3 (full thickness skin loss involving damage to the subcutaneous tissue) present on admission, 3 stage 4 (full thickness skin loss) present on admission, and 3 unstageable pressure ulcers present on admission. Review of the pressure ulcer care plan last reviewed 05/04/21 revealed Resident #4 was at high risk for pressure ulcers with a goal of remaining free from new skin breakdown through the next review date. Further review of Resident #44's care plan did not reveal a care plan for actual impairment to skin integrity. An interview with the Administrator on 08/05/21 at 06:15 PM confirmed there was no care plan in Resident #44's chart for actual impairment to skin integrity. She stated Resident #44 should have had a care plan developed for actual impaired skin integrity and MDS nurses were responsible for developing care plans. An interview with MDS Nurse #1 on 08/10/21 at 04:03 PM revealed she initiated care plans for residents who were at high risk for developing skin integrity and if a resident had actual impaired skin integrity the wound care nurse was responsible for developing a care plan for impaired skin integrity. An interview with Wound Nurse #1 on 08/10/21 at 04:06 PM revealed she had been working as the wound nurse on and off for the past 3 to 4 months. She stated she was not aware of any expectation from Nursing Administration for her to develop care plans for actual skin impairment and thought MDS nurses developed and completed all care plans.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37538 Based on observations, record review and staff interviews, the facility failed to check for incontinence or provide incontinence care to a resident for 1 of 7 sampled residents dependent on staff for activities of daily living (Resident #77). Findings included: Resident #77 was admitted to the facility on [DATE] with diagnoses which included diabetes mellitus and dementia. The quarterly Minimum Data Set (MDS) dated [DATE] assessed Resident #77's cognition as being severely impaired and required extensive assistance with bed mobility, transfers, and toilet use. The bowel and bladder section of the MDS assessment revealed Resident #77 was always incontinent of bladder and bowel. The care plan last reviewed on 7/27/21 recognized Resident #77 was incontinent of bowel and bladder and required staff assistance with managing incontinence with the goal to manage incontinence with dignity through the next review. Interventions included provide appropriate size pad and brief, offer toileting assistance and/or incontinence care frequently, an provide prompt incontinence care with each episode. On 8/01/21 at 1:39 PM and observation with Nurse #7 was made of Resident #77 in bed. Resident #77 was wearing an incontinence brief that appeared firm as if full and a strong odor resembling urine was noted. Nurse #7 stated she would notify Resident #77's Nurse Aide (NA) incontinence care was needed and left the room. On 8/01/21 at 1:52 PM an interview was conducted with NA #9. NA #9 stated she arrived to the facility at 9:00 AM and was assigned to provide care to Resident #77 but hadn't had time to provide incontinence care to Resident #77 because she was assigned approximately 20 or more residents and it was nearly impossible to provide her assigned residents with the care they need. An interview was conducted on 8/05/21 at 10:40 AM with NA #7 who revealed she worked the unit with NA #9 on 8/01/21 where Resident #77 resided. NA #7 stated she didn't provide incontinence care for Resident #77 on 8/01/21. NA #7 revealed with only 2 NA staff members on the unit it could be challenging to provide incontinence care timely. An observation was conducted on 8/01/21 at 2:00 PM of NA #9 getting Resident #77 ready for a bed bath. NA #9 removed the bed covers and it appeared Resident #77 was wearing the same incontinence brief that remained firm as if full and a strong odor of urine was noted. When NA #9 unfastened Resident #77's incontinence brief it was heavily saturated with urine and there was a second incontinence brief that appeared heavily saturated with urine. During incontinence care Resident #77's peri area didn't appear red or irritated. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/01/21 at 3:10 PM the Administrator revealed there were 2 NA call outs and typically the unit had 3 to 4 NA staff. The Administrator revealed she was able to get 2 NA staff to come in and help with resident care and at approximately 12:00 PM one NA was assigned to help on the unit where Resident #77 resided. On 8/01/21 at 3:14 PM a second interview was conducted with Nurse #7. Nurse #7 revealed she asked NA #9 to provided incontinence care for Resident #77. Nurse #7 stated she did not provide incontinence care for Resident #77. An interview was conducted on 8/05/21 at 11:02 AM with Unit Manager (UM) #2. UM #2 stated resident care should be provided timely and residents should be checked and not left incontinent for a long period of time. UM #2 was unsure of what happened with Resident #77's care on 8/01/21 and preferred not to comment. An interview was conducted with the Administrator on 8/05/21 at 6:17 PM. The Administrator stated staffing on 8/01/21 was challenging and if Resident #77 had a history of large incontinent episodes and didn't use the call light to ask for assistance that could be the reason her incontinent brief was heavily saturated on 8/01/21. The Administrator stated she didn't think Resident #77 went without incontinence care for a long period of time but ideally NA staff check on residents every 2 hours to assist with needs.

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F 0684 Level of Harm - Minimal harm or potential for actual harm 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** 37538 Based on observations, record review, and staff interviews the facility failed to remove a dressing left in place for 14 days and reassess the skin and obtain treatment orders from the physician for scheduled wound care for 1 of 2 residents reviewed for skin conditions (Resident #66). The findings included: Resident #66 was admitted to the facility on [DATE] with diagnoses which included cancer lesions on the right shoulder, Alzheimer's, and dementia. The most recent Minimum Data Set (MDS) dated [DATE] assessed Resident #66's cognition as being severely impaired and activity of daily living needs as total assistance with bed mobility, transfers, and toilet use. The MDS indicated Resident #66 had no other skin problems with treatments in place to apply ointments and medications. Resident #66's care plan last revised on 6/12/21 identified a history of cancer growths to the right shoulder with the goal the growths remained free of infection through the next review. Interventions in place included treatments as ordered, observe the area daily for signs and symptoms of infection, pain, and changes in appearance and promptly report to the Medical Doctor (MD) or Nurse Practitioner (NP), and refer to a specialist as needed. Review of Resident #66's most recent skin assessments dated 7/20/21 and 7/27/21 indicated the skin was intact. Both assessments were completed by Nurse #5. An observation on 8/01/21 at 4:04 PM revealed Resident #66 resting in the bed on her right side. At the base of Resident #66's neck and right shoulder was a foam border dressing dated 7/19/21 with Nurse #5's initials. The dressing was not adhered to the skin to ensure the wound was protected. An interview and observation was conducted with Nurse #4 on 8/01/21 at 4:17 PM. Nurse #4 confirmed she was Resident #66's nurse and was not aware of a wound or any treatment orders. Nurse #4 observed the foam dressing was dated 7/19/21 and removed it to check the status of the wound. The back of the dressing was completely soiled with brown colored debris and reddish-brown colored drainage. The area of skin under the dressing appeared moist and pink to red in color with a dark red area in the center of the wound. The dark red area was approximately the size of pencil eraser with no odor and not actively bleeding. An interview was conducted with Unit Manager (UM) #1 on 8/01/21 at 4:30 PM. UM #1 observed the wound dressing and confirmed the dressing was dated 7/19/21 and not adhered to the skin to keep the wound protected. UM #1 observed the back of dressing was visibly soiled with blood colored debris and drainage with a small open area and the skin surrounding the open area was red to pink in color. UM #1 stated the nurse who initialed the dressing should have done an incident report and notified the MD to obtained treatment orders and expected either a Nurse Aide (NA) or nurse would've noted the dressing wasn't adhering to the skin or the date on the dressing was 7/19/21. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #66's physician orders revealed on 8/01/21 an order was written for fluorouracil 5% cream (used to treat superficial skin cancer). The order directed nurses to cleanse the area of the right shoulder and apply fluorouracil 5% cream topically and cover with a dry dressing daily and as needed for the diagnosis of neoplasm (an abnormal mass of tissue). During an interview on 8/03/21 at 10:52 AM the NP revealed she was notified about Resident #66's wound when the facility called to obtain treatment orders on 8/01/21. Today was first time the NP saw the wound and described the area of surrounding skin was red to pink and the center of the wound with a scant amount of bloody drainage. The NP stated the wound didn't appear infected and she would need to review the medical chart for any notes Resident #66 was scratching the area or had a history of this type of wound. The NP stated she would expect either a nurse or NA would've seen the date on the dressing and expected the nurse to notify her to obtain treatment orders. The NP revealed having the dressing on for 14 days put the wound at risk for infection but indicated there were no signs the wound was infected, but she would refer Resident #66 to the wound clinic. An interview was conducted on 8/3/21 at 4:23 PM with Nurse #5. Nurse #5 confirmed she applied the dressing dated 7/19/21 and the skin wasn't open and it appeared as if Resident #66 had been scratching the area. Nurse #5 stated she made a nursing judgement to clean the area and cover with a dressing and didn't think it required further treatment therefore she didn't notify the MD or NP. Nurse #5 explained when she noted an open area on a resident's skin, she would notify the wound nurse who checked the skin and if needed obtained treatment orders. Nurse #5 confirmed she documented the skin assessment on 7/27/21. When asked if she observed the dressing, she applied on 7/19/21 was still in place did that trigger her to change the dressing or notify the MD or NP. Nurse #5 stated she didn't observe the area during her skin assessment on 7/27/21. An interview was conducted 8/05/21 at 6:28 PM with the Administrator. The Administrator revealed skin assessments should be done correctly and the protocol was if a new skin issue was identified the nurse would notify the MD and if needed obtain an order for treatment. The Administrator expected nurses not to leave a dressing on for 14 days and to follow the protocol for skin assessments.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39037 Based on observations, record review, and staff and Wound Care Nurse Practitioner (NP) interviews the facility failed to provide pressure ulcer care per physician orders for 1 of 4 residents (Resident #44) reviewed for pressure ulcer care. Findings included: Resident #44 was admitted to the facility 01/22/21 with diagnoses including seizure disorder and anxiety. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #44 had 2 stage 3 (full thickness skin loss involving damage to the subcutaneous tissue) present on admission, 3 stage 4 (full thickness skin loss) present on admission, and 3 unstageable pressure ulcers present on admission. Review of Resident #44's treatment orders in part were as follows: a. Cleanse right lateral (side) calf wound with 0.5% dakin's solution (an antiseptic), pat dry, pack with dakin's soaked gauze, and cover with a dry dressing daily and prn (as needed) ordered 06/19/21 b. Cleanse right ischial wound (the curved bone forming the base of each half of the pelvis) with wound cleanser, pat dry, pack with wet dakin's 0.5% solution moistened gauze, and cover with dry dressing daily ordered 7/21/21 c. Cleanse sacral wound (a triangular bone in the lower back form from fused vertebra) with wound cleanser, pat dry, pack with wet dakin's 0.5% solution moistened gauze, cover with dry gauze, and cover with dry dressing daily ordered 07/12/21 d. Cleanse left ischial wound with wound cleanser, pat dry, pack with wet dakin's 0.5% solution moistened gauze, cover with dry gauze, and cover with dry dressing daily ordered 07/12/21 e. Cleanse left calf wound with 0.5% dakin's solution, apply dakin's moistened gauze, cover with dry gauze, and secure with a foam dressing daily and prn ordered 06/22/21 An observation of the Nurse #9 on 08/02/21 at 02:15 PM performing wound care to Resident #44's right calf, right ischial wound, sacral wound, left ischial wound, and left calf wound revealed dakin's 0.25% solution was used for all wound care requiring dakin's solution instead of the ordered dakin's 0.5% solution. Nurse #9 removed the old dressing to Resident #44's left calf wound, cleaned the wound with dakin's 0.25% solution, applied dakin's 0.25% solution moistened gauze, and covered the wound with 2 foam dressings. No dry gauze was applied on top of the moistened gauze and the adhesive on the foam dressings was observed to be touching the wound bed. (continued on next page)

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	345489	A. Building B. Wing	08/13/2021

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Nurse #9 on 08/02/21 at 03:56 PM revealed she did not normally perform wound care but the Wound Care Nurse was on vacation so she was assisting with wound care. She stated she looked for dakin's 0.5% solution but could not find any so she used the dakin's 0.25% solution instead. Nurse #9 stated since the dakin's 0.5% solution was unavailable she should have notified the wound care provider and gotten an order to use dakin's 0.25% solution or other wound care product until the dakin's 0.5% solution was available. She stated she missed the step of applying dry gauze over the moistened gauze on Resident #44's left calf wound and did not see the adhesive from the foam dressings were touching the wound bed of Resident #44's left calf wound. An interview with the Wound Care NP on 08/04/21 at 10:09 AM revealed she should have been notified dakin's 0.5% solution was not available when performing Resident #44's wound care and she could have given an order to use the 0.25% dakin's solution instead. She also stated if the dry gauze had been applied over the moistened gauze as ordered to Resident #44's left calf wound that would have prevented the wound bed from being in direct contact with adhesive. The Wound Care NP stated adhesive should never be in direct contact with a wound bed. An interview with the Administrator on 08/05/21 at 06:15 PM revealed she expected nursing staff to follow physician's orders and if the dakin's 0.5% solution was not available the provider should have been notified and a new order obtained. She stated dry gauze should have been applied over the moistened gauze on Resident #44's left calf wound so adhesive did not touch the wound bed.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37014 Based on observations, record review, and staff, resident, Radiologist and Manufacturer Representative interviews, the facility failed to ensure positioning and securement was according to manufacturer recommendations to provide a safe facility van transport for 1 of 5 sampled residents reviewed for accidents (Resident #70). During a facility van transport on 05/17/21, Resident #70 slid partially out of the wheelchair causing his knee and lower legs to hit the floor of the van, resulting in minor bruising noted to his knee and no reported pain. Resident #70 was assisted back to into his wheelchair without an assessment by a licensed nurse or medical professional. On 05/19/21, Resident #70 was sent to the hospital due to increased pain and subsequently diagnosed with a mildly displaced oblique (slanting) fracture of the distal tibia (inner bone between the knee and ankle) and nondisplaced (bone is broken but not out of alignment) fracture of the distal fibula (outer bone between the knee and ankle). Resident #70's leg was placed into a cast secondary to left tibia fracture and he returned to the facility the same day. Immediate Jeopardy began on 05/17/21 when Resident #70 slid out of the wheelchair during a facility van transport and sustained a leg fracture. Immediate Jeopardy was removed on 08/10/21 when the facility implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of D (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) to ensure monitoring systems put into place are effective. Findings included: The undated manufacturer's instructions utilized by the facility and titled, Vehicle Anchorages and Accessories for 4-Point Wheelchair Securement Systems, read in part: Securing Wheelchair: Center wheelchair facing forward in securement zone. Attach front retractor or manual front anchorage points and lock them in place. If using deluxe or max retractors, ensure the retractors are used at the front. Completely pull out each webbing and attach J-hook to solid frame member. Attach rear retractors or rear manual tiedowns into floor anchorage points and lock them into place. Completely pull out each webbing and attach hook to solid frame member. Move wheelchair forward and back to remove webbing slack or manual tension webbing with retractor knobs. Lock wheelchair brakes (or power off electric chair). Attach retractable combination lap/shoulder belt: attach tongue on end of shoulder belt to buckle stalk closest to the wall. Pull the shoulder belt over occupant's chest and insert tongue into the buckle stalk closest to the aisle. Adjust shoulder belt height so that shoulder belt rests on occupant's shoulder, making sure the shoulder belt does not rub against the occupant's neck. The manufacturer's instructions provided no guidance regarding occupants sitting on cushions or mechanical lift slings while they were seated in their wheelchair during transport. Resident #70 was admitted to the facility on [DATE] with multiple diagnoses that included an autoimmune disease that attacks the central nervous system, muscle weakness and depression. The quarterly Minimum Data Set (MDS) dated [DATE] assessed Resident #70 with intact cognition for daily decision making. The MDS noted he used a wheelchair for mobility, required limited staff assistance with locomotion and total staff assistance with transfers. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Resident Incident Report dated 05/17/21 at 12:00 PM noted Resident #70 slid out of the wheelchair while in the facility van during transport and sustained bruises to the left upper and lower shin that were treated with Topical Antibiotic Ointment (TAO) and dry dressing. The facility's investigation, dated 5/19/21 and completed by the Administrator, revealed in part: on 5/17/21 at approximately 11:30 AM, Resident #70 slid out of the wheelchair while in the facility van being transported back to the facility from an appointment. Resident #70's wheelchair was correctly secured with both chest/lap belt and four-point restraints. However, Resident #70 was noted to have a mechanical lift pad under him and no cushion in the wheelchair. The Transport Driver (TD) #1 was notified by Resident #70 that he was sliding out of the chair, she maneuvered the facility van to a safe location and once the van was stopped, she noticed that Resident #70's upper body (above the waist) was still in the wheelchair being secured by the chest/lap belt and his legs were noted on the floor of the van. Resident #70 was assisted back into the wheelchair by TD #1 and Nurse Aide (NA) #1 and returned to the facility. Nurse #1 was notified of the incident by TD #1 at approximately 12:30 PM and Resident #70 confirmed to Nurse #1 he had slid out of the wheelchair during transport and denied any pain. Upon nurse assessment, it was noted he had bruises to his legs which were cleaned with wound cleanser and TAO and a dry dressing were applied. On 5/19/21, the Nurse Practitioner (NP) was notified Resident #70 complained of pain in his left ankle and orders were received for a 2-view left ankle x-ray. On 5/19/21 at 11:16 PM, TD #1 provided a return demonstration of how Resident #70 was secured in the wheelchair of the facility van and able to demonstrate proper use of the four-point wheelchair restraints and chest/lap securement system. On 5/19/21 at approximately 2:02 PM, x-ray results were received that confirmed Resident #70 had a mildly displaced oblique fracture of the distal tibia and nondisplaced fracture of the distal fibula. Orders were obtained by the NP to send Resident #70 to the ED for evaluation and treatment and he returned to the facility at 11:00 PM with a cast and orders to follow-up with the Orthopedist within one week. The facility's investigation determined the following root causes: a) Resident #70 was moved after a fall in the facility van without a licensed nurse or medical professional assessment, b) Resident #70 did not have a cushion in his chair and had the mechanical lift sling under him which contributed to him sliding out of the wheelchair of the van, and c) Nurse #1 failed to notify the physician of the incident which resulted in a delay of treatment. During an interview on 08/03/21 at 8:52 AM, Resident #70 recalled he was seated in his wheelchair, headed back to the facility in the transport van, when TD #1 slammed on the brakes and he flew forward out of the wheelchair into the dashboard of the van. Resident #70 stated his wheelchair was secure but he did not have a chest or seat belt in place. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a follow-up interview on 08/04/21 at 4:21 PM, Resident #70 clarified when he was seated in the van in his wheelchair, the wheelchair was securely strapped to the floor and now reports he did have the lap/chest belt in place but added the straps were loose and not tight. He stated he was not sure how fast TD #1 was driving but recalled a truck pulled out in front of the van and when TD #1 slammed on the brakes he flew up in the air hitting his knee on the console that was located in between the driver's seat and the passenger seat. Resident #70 denied hitting his head or chest, just his knee which caused the fracture. When asked how he could have reached the console at the front of the van if the lap/chest belt was fastened, he stated it was loose and went with him but never came unfastened. He added the wheelchair then tipped forward to the floor when he landed on the console. When asked how far back he was from the console, he replied 8 to 9 feet and when asked to clarify the distance again, he stated he flew in the air with the lap/chest belt still attached 8 to 9 feet and his knee hit the console. Resident #70 confirmed he did not have a cushion in the seat of his wheelchair prior to or on the day of the incident. During an interview on 08/04/21 at 7:50 AM, TD #1 revealed prior to departure, she made sure Resident #70's wheelchair was secured in the facility van by locking the wheelchair brakes, applying the 4-floor securement locking system to the wheelchair, and attaching the chest/lap belt. TD #1 stated as she was driving down the road, she heard Resident #70 state he was sliding out of the chair, she immediately pulled over to the side of the road and she and NA #1 noticed he had slid down in his wheelchair, with his legs out front and slightly toward the left side and his bottom was still on the edge of the seat with his legs on the floor. She added the chest/lap belt was intact and prevented him from sliding all the way out of the wheelchair. TD #1 recalled Resident #70 had a scratch on the top of his knee that was not bleeding or open and when asked if he was in any pain, he replied 'no.' She added Resident #70 repeatedly asked them to pull me up so both she and NA #1 pulled him back up into the wheelchair, checked to make sure all straps were secure and then continued driving back to the facility. Once back at the facility, TD #1 reported the incident to Nurse #1 and Assistant Director of Nursing. TD #1 explained at the time of the incident she wasn't aware that she should not have moved Resident #70 to reposition him back up straight in the wheelchair after the incident but had since received education that prior to moving a resident after an incident or fall, she was to notify the Nurse. During a follow-up interview on 08/05/21 at 8:43 AM, TD #1 explained Resident #70 had no cushion in the seat of his wheelchair but was sitting on a shower lift sling (one with holes to allow water drainage) underneath his bottom and not the normal fabric mechanical lift sling. TD #1 added normally, when using a mechanical lift to assist a resident into the wheelchair, once the resident was seated, they removed the lift sling; however, she was not sure why facility staff had used the shower sling when transferring him to his wheelchair for transport and felt it was left in his wheelchair to assist hospital staff in transferring him during his appointment. TD #1 restated the van's securement floor straps and lap/chest belt were securely attached to Resident #70's wheelchair prior to leaving the hospital and he never slid all the way to the floor from his wheelchair. TD #1 could not explain how Resident #70 was able to slide out of his wheelchair during transport and stated it was possible the hospital staff had not positioned him correctly in the wheelchair after he was examined. She added there was no vehicle that pulled out in front of the van causing her to slam on the brakes and Resident #70 was not thrust forward hitting the console at the front of the van. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During interviews on 08/04/21 at 6:55 AM and 6:15 PM, NA #1 confirmed she had gotten Resident #70 ready for his appointment the morning of 5/17/21. NA #1 explained she couldn't find the normal mechanical lift sling to transfer Resident #70 to his wheelchair so she got one of the shower mesh slings from laundry to use instead. She added, normally she would remove the sling once the resident was placed safely in the wheelchair but left it underneath Resident #70 in case the hospital staff needed to use it to transfer him while at his appointment. NA #1 could not recall if Resident #70 had a cushion in the seat of his wheelchair the morning of 05/17/21. NA #1 verified she was present in the facility transport van with TD #1 and Resident #70 on 05/17/21 when he slid partially out of his wheelchair and confirmed TD #1's statement of what had occurred. She added on the way back to the facility, there was no traffic and no vehicle that pulled out in front of the van causing TD #1 to slam on the brakes nor did Resident #70 fly forward out of his wheelchair from the back of the van and hitting the front console. During a telephone interview on 08/04/21 at 6:23 PM, Nurse #1 stated once Resident #70 returned from his appointment on 05/17/21 she was notified by TD #1 that he had slid partially out of his wheelchair during transport. TD #1 reported to her that Resident #70 was repositioned back up straight in his wheelchair once the van was stopped and she had noticed a small abrasion/scratch on his knee. Nurse #1 stated she immediately completed an assessment which included checking for signs and symptoms of a fracture with no abnormalities noted other than a scratch and some bruising to his right knee which she treated with TAO and applied a dry dressing. She added Resident #70 complained of no pain and when asked what happened he confirmed what TD #1 had reported to her. Nurse #1 added when she provided care to Resident #70 on 05/18/21, he complained of pain and was given Tylenol. She added when she assessed his leg on 05/18/21, there were no signs of obvious fracture and the only injury noted was the scratch and bruising to his knee. On the morning of 05/19/21, Resident #70 complained of increased pain, she notified the NP and an order was obtained for an x-ray. Nurse #1 explained she didn't notify the NP on 05/17/21 because Resident #70 complained of no pain, did not hit his head and upon assessment there was no signs of a fracture. Nurse #1 stated Resident #70 never mentioned to her at any point the lap/chest belt was loose and he flew forward in the van hitting the console and if he had, she would have immediately notified the Physician or NP. The Nurse Practitioner (NP) progress note dated 05/19/21 read in part, Resident #70 seen for assessment of left leg pain. Per nursing staff, Resident #70 had an appointment on 05/17/21 and upon return to the facility, he slid out of the wheelchair in the facility transportation vehicle. Resident #70 reports he bent his left and right leg underneath the wheelchair at the time of his fall and since then has had increased pain in the left leg. The physical exam noted internal rotation of the left lower extremity and increased pain on palpation. Orders were given for: Norco (pain medication) 5/325 milligrams every 4 hours as needed for pain, topical antibiotic ointment for the left shin abrasion and transfer to the Emergency Department (ED) for treatment of left tibia-fibula fracture. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During interviews on 08/04/21 at 11:30 AM and 3:42 PM, the NP stated she was notified the morning of 05/19/21 that Resident #70 had an accident while being transported in the facility van on 05/17/21 and his leg was injured and painful at which time, she gave orders for pain medication and to obtain an x-ray of his lower leg. The NP stated when she arrived at the facility on 05/19/21 and assessed Resident #70's leg, she noticed it was swollen with bruising to his knee but there were no obvious signs of a fracture such as deformity or protrusion. However, once the results of the x-ray were received it showed a definite fracture and orders were given to send Resident #70 to the ED for evaluation and treatment. The NP stated Nurse #1 should have notified her on 5/17/21 when the incident occurred instead of waiting 2 days and while it would not have changed the outcome, it did cause a delay in his treatment. The NP explained had she been informed of the incident on 05/17/21, she would have been able to identify the fracture sooner. During a telephone interview on 08/10/21 04:30 PM Nurse #2 confirmed she was assigned to provide care to Resident #70 during second shift on 05/17/21, 05/18/21 and 05/19/21. Nurse #2 stated when she reported to work the afternoon of 05/17/21, she was not told of the incident that occurred in the facility transport van and did not find out about the incident until she reported to work the afternoon of 05/18/21. Nurse #2 did not recall observing Resident #70's leg on 05/18/21 or of him complaining of any pain. She explained when he did voice pain, which was usually after therapy, he was provided pain medication that was effective. On 05/19/21 when she reported to work, he was in the process of being sent out to the hospital due to a confirmed leg fracture and when he returned from the hospital that evening, he had cast on his leg. Results of the mobile x-ray completed at the facility on 05/19/21 noted Resident #70 had a 2-view ankle x-ray which indicated in part, there is a mildly displaced fracture of the distal tibia and a non-displaced fracture of the distal fibula compatible with fractures of indeterminate (not exactly known) age in the appropriate clinical setting. Severe osteopenia (reduced bone mass) is noted. During a telephone interview on 08/05/21 at 3:00 PM, the Radiologist reviewed Resident #70's x-ray result and stated the tibia fracture looked acute (severe and sudden in onset) to him. He explained there was no healing callous (the bony healing tissue which forms around the ends of broken bone) observed on the x-ray which would have typically been noted on the x-ray 2 weeks after a fracture. The fibula fracture was a hairline fracture and hard to see. The Radiologist explained normally, a person would be in a lot of pain with this type of fracture but Resident #70 was not weight bearing. The Emergency Medical Service Transfer: Emergency Department to Floor Report dated 5/19/21 at 5:06 PM read in part, reason for visit: fall, leg pain, unspecified fracture of left tibia, initial encounter for closed fracture, unspecified fracture of shaft of left fibula, initial encounter for closed fracture. Pain assessment: patient is not reporting any pain. The hospital discharge after care notes dated 05/19/21 read in part, reason for visit - fall, leg pain. Discharge diagnoses were listed as closed left tibial fracture and fracture of left fibula. During a telephone interview on 08/06/21 at 9:26 AM the Medical Director (MD) did not recall being notified of the incident on 05/17/21 involving Resident #70 but stated the NP was notified and evaluated him on 05/19/21. The MD explained Resident #70's bones were very weak and brittle and simply sliding out of the wheelchair could cause his bones to break. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 08/04/21 at 9:07 AM, TD #2 stated he typically transported residents to their appointments in the morning and TD #1 took over in the afternoon. TD #2 explained when securing a resident in the facility transport van, he locked the brakes on the resident's wheelchair, secured the wheelchair in place using the 4-point securement floor straps, placed the lap/chest belt across the resident, and then shook the wheelchair side-to-side, which caused the straps to automatically tighten, to ensure the wheelchair was secure. TD #2 confirmed on the morning of 05/17/21, he transported and dropped off Resident #70 and NA #1 at his appointment with no incident. He added, TD #1 picked Resident #70 and NA #1 up later that afternoon to bring them back to the facility. During an interview, the Administrator recalled on 5/19/21, she was informed Resident #70 was complaining of increased pain after an accident in the facility transport van and an order was received from the NP for a 2-view x-ray. The Administrator immediately went to assess Resident #70 and described his legs as twisted slightly at baseline due to his diagnosis of autoimmune disease. She recalled his left leg was warm and swollen and he complained of pain but displayed no obvious signs of fracture. She added, to be honest, I thought it was cellulitis. She discussed the incident with TD #1 and NA #1 as well as Resident #70 whose details of the event continued to change. She added Resident #70 never stated he had flown forward from the wheelchair into the dashboard and had no injuries to support that statement. After it was determined he did sustain a fracture, she immediately started an investigation which identified the concern that Nurse #1 failed to notify the MD/NP of the incident on the day it occurred. In addition, she indicated they also concluded he was left sitting on the shower mesh mechanical lift sling when placed in his wheelchair with no cushion. She explained since the sling used was a slippery material, they felt if there had been a cushion, that she described as made with a rubbery type material, in the seat when he was placed in the wheelchair on the sling, then it wouldn't have been as slick making it less likely for him to slide out of the wheelchair. The Administrator stated a plan of action was developed on 05/19/21 to address the prompt notification of the physician and Responsible Party (RP) of a resident's change in condition and was presented to the Quality Assurance (QA) committee on 05/20/21. She explained the plan of action included: staff education that was provided to all licensed Nurses and Medication Aides related to notifying the physician and RP promptly of any change in condition; audits of clinical documentation and incident/accident reports to ensure notifications were completed timely; and monitoring systems put into place to ensure continued compliance that were still ongoing. The Administrator stated they never considered the possibility the chest/lap belt was not properly secured at the time of the incident since both TD #1 and NA #1 confirmed it was intact; therefore, the possibility Resident #70 was not secure at the time of the incident was not considered a factor when trying to determine a possible root cause. The Administrator confirmed they were unable to determine what actually occurred to cause Resident #70 to slip out of the wheelchair and stated she felt it was an unfortunate, freak accident. A telephone interview with a Representative of the manufacturer of the wheelchair safety securement system utilized by the facility was conducted on 08/06/21 at 3:36 PM. The Representative stated they recommended using the chest/lap belt when transporting a resident in the transport van by placing the lap belt underneath the arm rest and across the lap tightly to prevent someone from sliding out of the wheelchair. The Representative added if the lap/chest belt was properly applied and secured according to the manufacturer's instructions, then Resident #70 should not have been able to slide out of the wheelchair during transport. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An observation of a shower mesh mechanical lift sling that was used to transfer Resident #70 was conducted with the Administrator on 08/04/21 at 4:29 PM. The base and sides of the sling were a slippery, mesh material with fabric straps on each end that attached to the mechanical lift when used for transfers. An observation of the facility transport van and follow-up interview was conducted on 08/05/21 with TD #1. Surveyor #1 was seated in the transport wheelchair used to transport Resident #70 to his appointment on 05/17/21. TD #1 locked the brakes of the wheelchair, attached the 4-floor securement hooks onto the wheelchair and checked to make sure the locking system was secure. TD #1 then attached the chest/lap belt and checked for securement. The wheelchair was placed in the middle just behind the driver and passenger seats. When the wheelchair was shaken side-to-side, the floor straps and locks remained secure. When leaning forward from a sitting position, the lap belt tightened while the chest/shoulder strap gave approximately 12 inches allowing the upper body to lean forward before tightening and preventing a fall out of the wheelchair. During the observation, TD #1 described Resident #70 was seated in the wheelchair leaning slightly toward the right side with his legs angled toward the left, in between the footrests of the wheelchair. TD #1 explained when Resident #70 slid out of the wheelchair during transport and she stopped the van, his right knee landed on the floor of the van and his lower left and right legs were on the floor underneath the left footrest of the wheelchair. She restated the lap/chest belt remained in a locked position but his lower body had slid down from under the lap belt allowing his knee to hit the floor while his bottom had remained resting on the edge of the seat. The Administrator and Regional Clinical Consultant were notified of Immediate Jeopardy on 08/06/21 at 2:06 PM. The facility provided the following Credible Allegation of Immediate Jeopardy Removal: 1) Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance: On 5/17/2021 at approx. 11:30am, Resident #70 was being transported in the facility's van back to the facility following an appointment accompanied by Transport Driver #1 and Nurse Aide #1. During transport, Resident #70 informed Transport Driver #1 he was sliding out of his wheelchair. Transport Driver #1 immediately pulled the van over to the side of the road and both she and Nurse Aide #1 noted Resident #70 had slid down, but he was not completely out of his wheelchair. Transport Driver #1 reported that Resident #70 had his upper body (above the waist) was still in the wheelchair, being secured by the chest/lap belt. Per Transport Driver #1 Resident #70 right knee was on the floor of the van and his left leg was on the floor and underneath the footrest of the wheelchair. Transport Driver #1 and Nurse Aide #1 assisted Resident #70 back into wheelchair, making sure that his seat/lap belt and wheelchair were all secure and continued back to the facility. At approx. 12:30, Transport Driver #1 arrived back to the facility with Resident #70. Transport Driver #1 notified Nurse #1 of Resident #70 sliding out of the wheelchair. In a nursing note by Nurse #1 on 5/17/2021 at 4:02pm read in part that Resident #70 returned from appointment with no new orders. Transport Driver #1 reported that Resident #70 slid out of wheelchair and had bruises to his leg. Resident #70 confirmed incident. Bruises on left leg cleaned with wound cleanser and covered with TAO and dry dressing, treatment provided by Nurse #1. Nurse #1 noted resident denied pain. Responsible Party contacted, no answer, nurse monitoring. Incident report, fall and pain assessment completed by Nurse #1. Nurse #1 reported that she completed an assessment which included checking for sign/symptoms of a fracture with no abnormalities noted other than the scratch and bruising to his left leg in which she treated with the TAO and a dressing. (continued on next page)

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	345489	A. Building B. Wing	08/13/2021

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Saturn Nursing & Rehabilitation	1930 West Sugar Creek Road Charlotte, NC 28262

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 5/18/2021 at 2:24 AM Nurse #2 noted resident status post fall with bruise to left leg with no complaints of pain and no acute distress. On 5/18/2021 Nurse #1 reported during her shift (1st) that resident #70 complained of pain to left leg and was given Tylenol that she reported was effective, she also reported she assessed Resident #70 leg and there were no signs of obvious fracture and the only injury noted was the scratch and bruise to his left leg. On 5/19/2021 at 9:44 am Nurse #2 noted bruising to left leg persist no complaints of pain or discomfort. On 5/19/2021 at 11:16am, Resident #70 complained of pain in the left ankle. Nurse #1 notified Nurse Practitioner #1 (NP). NP gave order for STAT two view x-ray to left ankle. On 5/19/2021 at approx. 12:30pm, Transport Driver #1 provided a return demonstration of how Resident #70 was secured in the wheelchair in the van to Administer and Regional Director of Operations. Transport Driver #1 was able to demonstrate proper use of the four-point wheelchair restraints and chest/lap belt to secure resident. During interview with Transport Driver #1 it was noted that Resident #70 did not have a cushion in his chair and the shower mesh sling had been left under the resident during transport. On 5/19/2021 at 2:02pm x-ray findings showed mildly displaced oblique fracture of the distal diaphysis of the tibia and nondisplaced fracture of the distal fibula. Severe osteopenia noted. Nurse Practitioner #1 gave order to send resident to emergency room for evaluation and treatment. 5/19/2021 at approx. 11:00pm Resident #70 returned to the facility with discharge diagnosis of closed left tibial fracture and fracture of the left fibula. Resident #70 is to follow up with CMC Orthopedics [NAME] within one week for reevaluation of leg fracture. Resident #70 was seen at CMC Orthopedics [NAME] on 5/24/2021 to continue with soft cast/splint. 8/2/2021 CMC orthopedic instructions to continue Fracture Brace every day to left lower extremity and to follow up in 3-4 months with new x-rays before appointment, appointment may be virtual. The facility failed to ensure proper positioning and securement of Resident #70 while in the transport van to prevent Resident #70 from sliding/falling out of wheelchair during transport. All residents that are transported have the potential to be affected when policies and procedures for proper positioning are not followed. 2) Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete: 100% of all drivers' education records were audited on 5/20/2021 and reaudited on 8/6/2021 by the facility Administrator and/or Director of Nursing, to ensure each driver receives necessary education to drive the van safely. All drivers noted to have necessary training and qualification to drive the facility Van to include what to do in-case of an emergency. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	100% of residents who has an incident or accident for the last 30 days starting on 4/17/2021 through 5/17/2021 were audited by the facility Director of Nursing on 5/20/2021 to identify any other resident with an incident or accident who was moved without a licensed nurse's assessment and to ensure proper MD and RP notification was completed. No other resident identified to be moved before licensed nurse assessed the resident. Findings of this audit is documented on the incident log audit maintained in the facility compliance binder. 100% of residents who had an incident or accident for the last 14 days starting on 7/23/2021 through 8/6/2021 were audited by the Regional Clinical Consultant on 8/6/2021 to identify any other resident with an incident or accident who was moved without a licensed nurse's assessment and to ensure proper MD and RP notification was completed. No other resident identified to be moved before licensed nurse assessed the resident. Findings of this audit is documented on the incident log audit maintained in the facility compliance binder. Audit was conducted by Nurse Management to include Director of Nursing, Assistant Director of Nursing, and Unit Managers of all residents that require a mechanical lift transfer to ensure lift slings is removed when transfer is complete. Initial Audit completed on 5/20/2021 and re-audit conducted on 8/6/2021. No issues noted. Regional Plant Operations Manager will audit/inspect the Q-straint system to include floor securements, chest/ shoulder and lap belt for proper engagement, securement, and function on 8/9/2021. Any identified issues will be corrected. Effective 8/6/2021 all non-licensed employees will not move any resident involved in an incident or accident, to include the incidents happened in the facility van when a resident experience any fall until the resident is assessed by the trained personnel. The Facility staff will ensure patient safety is maintained while waiting for help to arrive effective 8/6/2021. Executive Director, and/or Director of Nursing conducted initial education on 5/19/2021-5/20/2021 and re-education began on 8/6/2021 for current staff members to include contract staff. This education included the importance of ensuring resident is not moved from the floor when resident incident or accident occurred until proper assessments are completed by the appropriate, trained personnel (medical provider, licensed nurse and/or emergency medical transport and or paramedic). This education will be completed by 8/9/2021, any staff member not educated by 8/9/2021 will not be allowed to work until educated on this requirement. This education will be added on new hires orientation education for all new facility staffs. This education will also be provided annually for all facility staff to include drivers. In-service form stated The resident should be kept safe in the location observed until help arrived. If a resident fell in an area that put resident at further risk for injuries, extreme precautions must be taken to ensure resident's injuries are not exacerbated, should the resident be moved. Ex [TRUNCATED]

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20934 Based on observation, staff interviews and record review, the facility failed to provide large portions of food as ordered by the physician to 1 of 6 sampled residents at risk for weight loss (Resident #98). The findings included: Resident #98 was admitted to the facility on [DATE]. Diagnoses included constipation and anemia, among others. Medical record review revealed a physician order dated 10/21/20 for a regular diet with large portions at all meals due to a history of weight loss. A progress note written by the consultant Registered Dietitian (RD) dated 4/7/21 recorded in part that Resident #98 was referred due to poor food intake with an intake range of 25 - 100%. His physician prescribed diet was a regular diet with large portions. The RD recommended a nutritional supplement for weight gain. A quarterly Minimum Data Set Assessment, dated 7/10/21, assessed Resident #98 as dependent on staff for feeding assistance during meals and he weighed 142 pounds with no current weight loss. A care plan revised July 2021, recorded Resident #98 was at nutritional risk due to a history of weight loss and received a regular diet with large portions at all meals. The goal included some gradual weight gain; interventions included to monitor intake daily. During a continuous observation of the lunch meal tray line on 8/3/21 from 11:45 AM - 11:53 AM, the Assistant Dietary Manager (ADM) was observed to plate spinach and diced red skin potatoes using a one-half cup serving utensil for each with the following concerns noted: The ADM did not fill the one-half cup serving utensil when plating the spinach, but rather filled the utensil approximately 3/4 full, then filled the half cup serving utensil 1/4 full, for a total serving of one-half cup. The ADM was observed to plate one-half cup of diced red skin potatoes for Resident #98. Resident #98 did not receive a large portion of spinach or diced red skin potatoes. Review of the menu revealed a regular portion of spinach was one-half cup and a regular portion of diced red skin potatoes was one-half cup. The menu did not specify the portion of spinach or potatoes to be served to a resident with a diet order for large portions. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/3/21 at 12:03 PM, the Certified Dietary Manager (CDM) stated that when the ADM was hired two weeks ago, she stated, I don't cook, and so far, she had only received a couple days of training with two of the cooks. He stated that the Assistant Dietary Manager (ADM) had not yet trained with him. The CDM further stated that he informed the ADM that day (8/3/21) that she would need to have more days for training. The CDM further stated that he worked as the evening cook the day before, and therefore he was not in the kitchen to provide oversight for the lunch meal that day (8/3/21). He stated the ADM was filling in because the regular cook was off. The CDM stated that the facility did not have a written policy regarding large portions, but that the cooks were trained to serve one and one-half portion of a regular menu portion to residents with diet orders for large portions. He stated that the incorrect portion of spinach and potatoes served was an oversight and that Resident #98 should have received three fourths cup or six-ounce portion of spinach and red skin potatoes. An interview with the ADM occurred on 8/03/21 at 2:02 PM. The ADM stated that she was hired in her role three weeks ago and had only observed the CDM and one of the cooks a few times but that she had not received formal training in this role. The ADM stated in her previous responsibilities as a dietary supervisor, she did not cook, so since she assumed her role as ADM, she had to ask questions about providing the correct portions because she had not been trained. The ADM further stated that she served what she thought was a large portion, but that she was unaware that she did not provide the correct portion of food for a large portion of spinach and potatoes. She further stated it was an oversight because she had not been trained. The Administrator was interviewed on 8/04/21 at 12:29 PM and stated that she expected dietary staff to serve residents foods in the portion according to their diet order. The Administrator further stated the facility did not have a written policy on providing residents with large portions, but that dietary staff were trained to provide a resident with a diet order for large portions a regular portion and a half. A telephone interview occurred with the RD on 8/04/21 at 3:18 PM. The RD stated that she rounded at the facility every other week, reviewed/approved menus, and conducted monthly kitchen inspections. The RD further stated that she was not aware of dietary concerns related to staff serving incorrect portions, but that residents with a diet order for large portions should receive a regular portion and a half of each food item unless otherwise indicated.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39037 Based on observations and staff interviews the facility failed to keep the water collection device for the tracheostomy collar tubing off the floor, failed to perform hand hygiene before and after suctioning a tracheostomy, and failed to maintain sterile technique when suctioning a tracheostomy for 1 of 1 resident (Resident #44) reviewed for tracheostomy care. Findings included: 1a. Resident #44 was admitted to the facility 01/22/21 with diagnoses including respiratory failure and anxiety. A review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #44 was severely cognitively impaired and received tracheostomy care. Review of the care plan for tracheostomy care last updated 05/04/21 revealed the care plan goal was for Resident #44 to be free from infection/complications related to his tracheostomy. Interventions included suctioning as needed/per orders and monitoring tracheostomy site and secretions for signs or symptoms of infection. An observation of the water collection device for Resident #44's tracheostomy collar tubing on 08/01/21 at 12:41 PM revealed the water collection device was resting on the floor. An observation of the water collection device for Resident #44's tracheostomy collar tubing on 08/02/21 at 02:08 PM revealed the water collection device was resting on the floor. An observation of the water collection device for Resident #44's tracheostomy collar tubing on 08/03/21 at 09:04 AM revealed the water collection device was resting on the floor. An interview with the House Supervisor on 08/03/21 at 11:30 AM revealed the water collection device for Resident #44's tracheostomy collar tubing should not be on the floor. He stated when staff were in Resident #44's room they should make sure the water collection device for his tracheostomy collar tubing was not on the floor and if it was observed to be on the floor then it should be adjusted so it did not rest on the floor. An observation of the water collection device for Resident #44's tracheostomy collar tubing on 08/03/21 at 03:57 PM revealed the water collection device was resting on the floor. An observation of the water collection device for Resident #44's tracheostomy collar tubing on 08/04/21 at 07:15 AM revealed the water collection device was resting on the floor. An interview with the Director of Nursing (DON) on 08/04/21 at 08:42 AM revealed the nurse caring for Resident #44 should be keeping the water collection device for his tracheostomy collar emptied as needed and making sure the water collection device does not rest on the floor. She stated if the water collection device was resting on the floor it should be adjusted so it was not touching the floor. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Administrator on 08/05/21 at 06:15 AM revealed Resident #44's water collection device for his tracheostomy collar tubing should not be resting on the floor and nursing staff should be monitoring the tubing periodically to make sure it was not touching the floor. b. Review of the facility's policy titled Procedure: Tracheal Suctioning-Open Suctioning System last updated in 2019 read in part: perform hand hygiene according to facility policy/protocol, open suction kit, put on sterile gloves and remove the catheter (tube) from kit, attach catheter to suction source (the hand touching suction tubing is no longer sterile), apply suction and withdraw catheter in a rotating/twisting manner, discard catheter and gloves, and perform hand hygiene according to facility policy/protocol. Resident #44 was admitted to the facility 01/22/21 with diagnoses including respiratory failure and anxiety. A review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #44 was severely cognitively impaired and received tracheostomy care. Review of the care plan for tracheostomy care last updated 05/04/21 revealed the care plan goal was for Resident #44 to be free from infection/complications related to his tracheostomy. Interventions included suctioning as needed/per orders and monitoring tracheostomy site and secretions for signs or symptoms of infection. An observation of Unit Manager #1 on 08/01/21 at 12:41 PM revealed she was feeding Resident #44 his lunch. Resident #44 told Unit Manager #1 he needed to be suctioned. Unit Manager #1 left Resident #44's room to gather suctioning supplies and returned to the room. Unit Manager #1 closed the door, applied clean gloves, opened the package of sterile gloves and removed her clean gloves. The package of sterile gloves only contained 1 sterile glove and Unit Manager #1 put on the 1 sterile glove on her right hand, opened the door with her ungloved left hand, had a staff member place a clean glove on her left hand, closed the door, and began suctioning Resident #44 with her right hand. When Unit Manager #1 finished suctioning Resident #44 she removed her gloves and returned to feeding Resident #44. An interview with Unit Manager #1 on 08/01/21 at 03:07 PM revealed she should have performed hand hygiene before and after suctioning Resident #44 and she should have maintained sterile technique while suctioning Resident #44. She stated she should have gotten a new pack of sterile gloves that contained 2 sterile gloves before suctioning Resident #44. Unit Manager #1 stated not performing hand hygiene and ensuring she had the correct gloves on were oversights. An interview with the Administrator on 08/05/21 revealed hand hygiene should have been performed before and after suctioning Resident #44 and sterile technique should have been used while suctioning. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. An observation of Nurse #9 on 08/02/21 at 03:10 PM revealed she had been performing wound care for Resident #44. Resident #44 told her he needed to be suctioned. Nurse #9 removed her clean gloves, did not perform hand hygiene, applied sterile gloves, threw the glove wrapper away, unwrapped the sterile suction catheter, turned on the suction machine, removed Resident #44's passy miur valve (a valve that allows for verbal communication when placed on the hub of a tracheostomy tube), allowed the sterile suction catheter to touch Resident #44's beard, suctioned Resident #44, replaced the passy muir valve, and removed gloves. Nurse #9 began getting materials ready for an additional dressing change without performing hand hygiene after suctioning. An interview with Nurse #9 on 08/02/21 at 03:56 PM revealed she should have performed hand hygiene before and after suctioning Resident #44 and she did not because it was an oversight. Nurse #9 also stated tracheostomy suctioning was a sterile procedure and she should have used sterile technique. She also explained she did not see the sterile suction catheter touch Resident #44's beard before he was suctioned. An interview with the Administrator on 08/05/21 revealed hand hygiene should have been performed before and after suctioning Resident #44 and sterile technique should have been used while suctioning.

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F 0697 Level of Harm - Actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43443 Based on observations, record reviews, resident, staff and Medical Doctor (MD) interviews, the facility failed to manage and treat complaints of pain for 1 of 1 resident (Residents #410) reviewed for pain. The facility failed to manage Resident #410's pain during surgical wound dressing changes which resulted in the resident experiencing severe pain. The facility also failed to administer pain medication to Resident #410 during dressing changes as per the physician order. The findings included: Resident #410 was admitted to the facility from a hospital on 07/20/21 with a diagnosis of necrotizing (death of tissue) soft tissue infection of the sacrum. Review of the baseline care plan dated 07/20/21 revealed Resident #410 had a surgical wound to his mid buttocks. The care plan goal was for Resident # 410's wound to heal and return home. Treatments included the wound to be packed and a fresh dressing applied two times a day. Review of Resident #410's admission Minimum Data Set, dated dated [DATE] revealed Resident #410 was cognitively intact and had a surgical wound. The MD's order dated 07/20/21 revealed the following order for wound care: Dakin's 0.25% solution (a solution used to kill germs and prevent germ growth in wounds) soaked gauzes were to be applied to the buttocks wound and covered with dry gauze and abdominal pads (which are non-adherent) secured with tape twice a day. Resident #410's physician progress note dated 07/22/21 revealed Resident #410 was admitted for wound care and dressing changes twice a day and will monitor and assist with pain management. Review of a NP progress note dated 07/23/21 revealed Reports his pain is increasing daily with dressing changes and rates his pain a 10/10. He reports with the medication his dressing changes puts his pain at 5-6/10. In a NP progress note dated 7/27/21, the NP documented that Resident #410 has been started on Dilaudid 4 mg 30 minutes prior to dressing change and his pain as been controlled. She documented per nursing resident did not exhibit increased pain response with wound care prior to his initiation on Dilaudid for his pain and he tolerated dressing change without Dilaudid dose. She noted she would discontinue the Dilaudid. Record review of progress note dated 08/02/21 written by the physician stated, Patient states the pain medication he is receiving inadequate to control his discomfort, stated he was receiving Dilaudid 2 mg prior to dressing change which is a decrease in the dosage first ordered and requesting to have medication returned to 4 mg Dilaudid before dressing change. He documented he will reinitiate his pain medication. Review of Resident #410's pain medication orders revealed the following: (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Some	7/20/21 - Acetaminophen 325 mg tablet give one tablet by mouth every six hours for pain 7/20/21 - Hydrocodone - Acetaminophen 5-325 mg, one tab every 6 hours for moderate pain as needed. 7/23/21 - Dilaudid 4 mg tablet take 1 tablet daily before dressing changes. 7/24/21 - Discontinued Hydrocodone - Acetaminophen 5-325 mg, one tab every 6 hours for moderate pain as needed. 07/26/21 - Hydrocodone - Acetaminophen 5-325 mg take one tablet by mouth every 6 hours as needed for pain 7/27/21 - Discontinue Dilaudid 4 mg by Nurse Practioner (NP). 8/02/21 - Dilaudid 4 mg tablet give one tablet by mouth 30 minutes before dressing changes for pain 8/03/21 - Dilaudid 4 mg tablet give one tablet for one time by mouth before dressing change. Do not give any more for today 8/3/2021. 8/05/21 - Discontinued Acetaminophen 325 mg tablet give one tablet by mouth every six hours for pain 08/05/21 - Acetaminophen 325 mg tablet take 1 tablet by mouth every 6 hours for pain (re-ordered) 8/06/21 - Dilaudid 4 mg tablet take one tablet by mouth one time for dressing change 8/06/21 - Discontinue Dilaudid 4 mg. 8/06/21 - Dilaudid 4 mg tablet take one tablet by mouth one time for dressing change - (second order for this med on 8/6/21). 8/06/21 - Dilaudid discontinued. A. 7/23/21 - 7/26/21: Per the Treatment Administration Record (TAR), Resident #410 had 8 dressing (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Some	changes and per the Medication Administration record (MAR) he was medicated 4 times with dressing changes. B. 7/27/21 - 8/1/21 - Per the TAR Resident #410 had 12 dressing changes and per MD orders no Diaudid ordered for dressing changes. Hydrocodone - Acetaminophen 5-325 mg was available for pain. C. 8/2/21 - 8/9/21 - Per the TAR Resident #410 had 16 dressing changes and per the MAR he was medicated 8 times with dressing changes. An observation of wound care on Resident #410 on 08/3/21 at 11:30 AM by a Wound Nurse # 2 revealed that resident #410 was medicated with Dilaudid 4 milligrams (mg) at 10:46 AM. The resident flinched in pain a few times while the packing was being replaced but said he was okay to continue. He stated the Dilaudid made all the difference. He stated the wound felt so much better when the dressing was fresh, but towards the 10-12 hour mark the dressing dried out and started to hurt. In an interview on 08/01/21 at 3:15 PM with Resident #410 he stated the packing and dressing change of his wound was very painful. He stated he saw the NP today and told her the current medication of Hydrocodone Acetaminophen 5-325 mg one tablet every 6 hours as needed was not strong enough for his pain during wound care. He stated on 07/23/21 he was ordered 4 mg of Dilaudid (an opioid pain medication), one tablet before wound care and it made a significant difference in his pain. Resident # 410 stated his pain level without the Dilaudid during wound care was 9-10 out of 10. He stated he would clench his fists; his body would be very tense, and he would be tearful. He stated his pain level during wound care with Dilaudid was 5-6 out of 10 and manageable. He stated things were going alright until the NP discontinued the Dilaudid on 07/27/21. In an interview with Resident #410's MD on 08/02/21 at 8:50 AM revealed he was not aware Resident #410 had any concerns with his dressings changes. He stated he was unaware the order for Dilaudid before wound care had been discontinued, and that Resident #410 had complained about severe pain with wound care without the medication. The physician stated he would talk with Resident #410 and the NP. In an interview on 08/03/21 at 10:16 AM with the NP revealed that Wound Nurse #1 told her she forgot to give Resident #410 his Dilaudid before his wound care on 07/26/21 and she felt he tolerated the dressing change well without pain medication. The NP stated she then decided to discontinue the Dilaudid. In an interview with Resident #410 on 08/04/21at 9:40 AM he stated he asked the NP why he wasn't getting Dilaudid for dressing changes. She stated that Wound Nurse #1 had told her he was not having pain during dressing changes. Resident #410 stated he told her he was surprised by that because when his dressing changes were done without Dilaudid his pain level was nine-ten out of ten, and with Dilaudid his pain was a five-six out of 10 and manageable. He stated every day after the Dilaudid was discontinued he told every wound nurse how much pain he was in during dressing changes. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Some	On 08/04/21 at 12:53 PM a phone interview was conducted with Wound Nurse #1 who stated initially Resident #410 did not mention pain with his wound care, but on 07/26/21 halfway through the wound care he told her he needed the Dilaudid before he got his dressing changed. She stated she did not know anything about that order. Resident #410 told Wound Nurse #1 the order for Dilaudid was written on 7/23/21. She stated she asked another nurse about the order, she didn't know her name, and the nurse pulled up the order in the computer so Wound Nurse #1 could verify. Wound Nurse #1 stated she discussed the order with the NP and told the NP he exhibited no signs of pain during wound care, and since his admission she had seen him up walking, sitting outside and smoking so he seemed to be fine An interview conducted on 08/05/21 at 2:10 PM with the Administrator revealed it was her expectation for physician pain medication orders to be followed as written. She stated she had seen the wound and knew it was bad. In a telephone interview with Nurse #3 on 08/06/21 at 06:06 PM she stated she performed wound care on several occasions and the wound was massive, so wide and deep. The first day she changed the wound the Dilaudid had not been ordered and he experienced a lot of pain. Once the Dilaudid was ordered and she could pre-medicate him she saw a big difference with his pain being decreased. She stated the dressing change was a very painful procedure and those nerve endings were not dead.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 37014 Based on observations, record reviews and resident and staff interviews, the facility failed to maintain sufficient nursing staff to ensure dependent residents received incontinence care as needed for 1 of 7 sampled residents (Resident #77). Findings included: This tag is cross-referenced to: F-677: Based on observations, record review, and staff interviews, the facility failed to check for incontinence or provide incontinence care to a resident for 1 of 7 sampled residents dependent on staff for activities of daily living (Resident #77). During an interview on 08/02/21 at 9:00 AM, Nurse #6 stated she typically worked weekends 7:00 PM to 7:00 AM and staffing was usually short with only 2 Nurses and 3 Nurse Aides (NA). Nurse #6 explained it was normal for her to report to work and find residents that were left wet or soiled from the previous shift. She stated when she noticed a resident hadn't been changed, it was usually during medication pass so she would inform the NA and they would provide care as soon as they could. Nurse #6 added there would be times residents wouldn't be changed for a couple of hours at a time. During an interview on 08/03/21 at 11:33 AM, the Nursing House Supervisor (NHS) stated he started his employment approximately one week ago and during that time, staffing was an issue. The NHS added he had frequently been pulled to cover a medication cart due to the staff shortage. He stated the staff were overworked and doing their best but when working short-staffed, they had to prioritize the care provided and residents were not getting the care needed. During an interview on 08/04/21 at 6:11 AM, NA #11 stated she normally worked second shift (3:00 PM to 11:00 PM) but frequently worked over on third shift (11:00 PM to 7:00 PM) due to staffing needs. NA #11 stated usually there were only 2 to 3 NA scheduled for the entire building which made it difficult to get resident care done such as incontinence rounds every 2 hours and answer call lights timely. During interviews on 08/04/21 at 6:21 AM AND 7:44 AM, NA #12 stated she normally worked second shift (3:00 PM to 11:00 PM) but frequently worked over on third shift (11:00 PM to 7:00 PM) due to staffing needs. NA #12 recalled on 07/29/21 she was the only NA assigned to west side on second shift and although other NAs helped when they could, there were 10 residents she wasn't able to provide incontinence care to during the shift and the third shift NA was informed so care could be provided. NA #12 stated on most nights there were only 3 NA scheduled for the entire building which made it difficult to get to everyone as often or frequently as needed and she felt rushed when providing resident care. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/04/21 at 6:31 AM, NA #13 stated she normally worked during the hours of 7:00 PM to 7:00 AM and the facility was frequently short-staffed. During the past 7 days she had worked, on at least 3 to 4 days, there were only 2 to 3 NA scheduled for the entire building. She explained when there were only 3 NA, she was able to touch every resident at least once per shift; however, when there were only 2 NA, she was unable to get to everyone and unfortunately, some residents went without incontinence care. During interviews on 08/04/21 at 6:55 AM and 3:52 PM, Nurse #8 stated she worked for a staffing agency and had only been working at the facility approximately one week with no formal orientation other than how to access the residents' medication administration records on the computer. Nurse #8 added the facility was short-staffed and sometimes there was only on NA assigned to the unit with weekends being the worst. She stated on 07/30/21 they only had 1 NA assigned to the unit and she tried to help the NA with incontinence care when she could because she knew the residents didn't want to be left wet or soiled. When working short-staffed, medications and treatments were her priority. Nurse #8 stated her body and mind were exhausted and this was breaking her. During a telephone interview on 08/06/21 at 9:01 AM, Unit Manager (UM) #2 stated staffing at the facility was a problem. UM #2 added when reporting to work residents were often found wet or soiled. She explained when there were only 2 or 3 NA scheduled for the entire building, they did the best they could but there was only so much they were able to do. During a telephone interview on 08/06/21 at 9:24 AM, NA #14 stated she had been employed at the facility for almost 2 years and worked the hours of 11:00 PM to 7:00 AM. NA #14 indicated there were times there were only 2 NA scheduled for the entire building which made it difficult to provide residents with the care needed. She explained when short-staffed, she tried to pass ice and water so fluids were available to the residents, answer call lights as quick as she could to make sure there wasn't an urgent need and monitor for incontinence to keep the residents clean and dry. She added some of the residents were a 2-person assist and if both NA were tied up providing care to other residents, then there would be residents that went without incontinence care. During a telephone interview on 08/06/21 at 2:36 PM, Nurse #9 reported when she had worked nights, there weren't enough NA scheduled and she would pitch in to help. She stated they tried to watch residents they knew were fall risks but couldn't be everywhere all the time and did the best they could. During a telephone interview 08/11/21 at 10:56 AM, NA #15 reported she had been employed by the facility since 2014, worked weekends 7:00 AM to 11:00 PM and the facility was often short-staffed. NA #15 explained there was only one NA scheduled for her assigned section when she reported to work on 08/01/21 and only one NA the evening of 07/30/21. She added when she arrived to work on 08/01/21, the smell of urine was overpowering and when there was only one NA assigned, there was no way feed all the residents who needed assistance, keep the residents dry and give showers. NA #15 stated the Administrator would pitch in to help with incontinence care and showers when needed. NA #15 indicated she had discussed the staffing situation with the Administrator and although the facility did use agency staff, a lot of them would not show up for work. NA #15 stated I'm burned out. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interviews on 08/01/21 at 12:08 PM and 8/05/21 at 03:58 PM, the facility Scheduler explained based on the current resident census and acuity needs, the preferred nursing staff minimums per day were: 5 nurses and 8 NAs 7:00 AM to 3:00 PM, 5 nurses and 8 NAs 3:00 PM to 11:00 PM and 3 nurses and 5 NAs 11:00 PM to 7:00 AM which was ideal, provided there were no-call outs. However, she indicated it was difficult to meet the preferred minimums, especially on the weekends, as they currently had 9 open nurse positions: 3 for first shift, 3 for second shift and 3 for third shift and 15 open NA positions: 6 for first shift, 7 for second shift and 2 for third shift which only added to the staffing challenges they currently faced. She added agency staff were utilized as much as possible; however, there were times they had no one to send. In addition, there had been a lot of call out outs on the evening shifts with no staff available for her to call on such short notice to come in and cover which would leave the shifts short. Frequently, she was pulled to the floor to cover as a NA or Med Aide when someone called out. The Scheduler stated on the days staffing was challenged, staff were not able to complete incontinence care rounds every 2 hours, residents might not get all their scheduled showers, dependent residents waited longer for assistance with meals, and call light response times took longer which had led to an increased number of falls. As a result, NA staff have voiced their frustration to her about not being able to give residents the care they deserved due to being so short staffed. The Scheduler confirmed administration was actively recruiting to fill the open positions and offered bonuses to staff when they signed up for extra shifts but she hated to ask them because they were all so burned out. During an interview on 08/01/21 at 3:42 PM, the Director of Nursing (DON) stated she had been employed at the facility for 4 months and they currently did not have a night shift weekend supervisor which left her on standby to cover when needed. The DON confirmed they faced staffing challenges due to open positions and call outs and utilized staffing agencies to supplement the schedule but the agencies did not always have someone to send. She explained the facility offered staff bonuses when they picked up extra shifts as well as offered sign-on bonuses for Nurses. She added the hiring process was ongoing and while they had received promising applicants some either didn't show up for the interview or orientation when hired. During an interview on 08/05/21 at 6:15 PM, the Administrator stated the hiring process was ongoing confirmed the facility faced a staffing challenge and stated their recruitment process remained ongoing. She added although they had received promising applicants, they either wouldn't call back or show up for a scheduled interview. The Administrator explained in addition to utilizing agency staff, they took flyers to local colleges to try and recruit NA graduates, advertised on social media sites, and offered sign-on bonuses for new staff. The Administrator stated she came in and worked the evening of 07/30/21 with another NA and while they do the best they can for the residents, she realized things were not getting done such as residents not getting the incontinence care like they need due to the current staffing challenges.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43222 Based on observation, staff interview, and record review the facility failed to have sufficient dietary staff to serve meals on time and failed to train the assistant dietary manager how to follow menus when serving portion sizes to residents. Findings included: This tag is cross-referred to: 1. F 809 Based on observations, interviews with residents, family and staff and record review, the facility failed to provide meals on time according to the meal schedule. This had the potential to affect 106 of 108 residents. 2. An observation of the lunch meal tray line began on 8/3/21 at 11:45 AM. The Assistant Dietary Manager (ADM) was serving the food behind the steam table. She was using (2) separate 4-ounce spoodles to serve the roasted potatoes and spinach vegetable dishes. The first meal tray was served a 3/4 of a serving of the 4-ounce spoodle of spinach. At 11:48 AM, Dietary Aide #2 called out for 2 large portion diet orders. The ADM served 1 scoop of potatoes plus 2 more potato pieces and 3/4 of a serving of the 4-ounce spoodle plus 1/4 serving more. At this time, the Dietary Manager (DM) took over behind the hot line and began serving the rest of the lunch meals. The tray line was halted numerous times during lunch meal service. At 11:53 AM the tray line was abbreviated when the DM was observed removing spinach from the steamer and placed on the stove in a saute pan. The DM stated at the time of the observation he ran out of spinach on the hot line and would ask the cook (ADM) why she did not prepare enough spinach. He further stated she was filling in because the regular cook was off that morning. The tray line resumed at 12:23 PM. At 12:30 PM, the tray line was stopped again to add spinach from the steamer. The tray line resumed at 12:40 PM. Interview with the ADM on 8/3/21 at 2:02 PM revealed she has not received any training in food preparation since she was hired. She stated she has only observed the DM and Cook #1 a few times because the dietary department has been so short staffed. The ADM further stated there has not been anyone to train her since she was hired 3 weeks ago. She indicated she has referenced the recipe book and sometimes asked Dietary Aide #1, who has worked in the dietary department for [AGE] years, about portion sizes. The ADM revealed meals were late on her first day of work, which was July 19th, because a cook quit that day. Breakfast was served around 9:30-9:45 AM and lunch did not go out until 1:30 PM. The Administrator and a few nurses came to help in the kitchen. Interview with the DM on 8/3/21 between 1:01 PM and 1:23 PM revealed when the ADM was hired, she said she did not cook and had a couple days of training with cooking/preparation. She has not worked with the DM since she had been hired. The lunch tray line on 8/3/21 was not started on time because there was not an adequate amount of spinach already prepared. The Registered Dietitian (RD) was interviewed on 8/4/21 at 3:18 PM. She revealed she provided clinical support, performed kitchen inspections monthly, and answered questions but did not train staff. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. Meal and Cart Times sheet stated the [NAME] Hall should have been served breakfast at 7:40 AM. South Hall should have been served lunch at 12:10 PM, and the last hall was to be served at 12:30 PM. An observation on 8/3/21 at 11:05 AM showed 2 staff working in the kitchen: 1 Dietary Aide and the ADM. At 12:50 PM, the first tray on South Hall was passed. On 8/4/21 at 10:05 AM, the breakfast meal and beverage carts arrived on [NAME] Hall. On 8/4/21 at 2:41 PM, an observation of Cook #1, the DM, the Administrator and Unit RN Manager #1 were working the lunch meal tray line in the kitchen (Meal & Cart Times sheet stated the last hall was supposed to be served at 12:30 PM). On 8/5/21 at 11:20 AM, an interview was conducted with Dietary Aide #1 (Faith) and she revealed she was told by the DM 2 dietary staff (1 aide and 1 cook) would have to cover an evening shift the other night. She stated it has been like this for a long time despite interviews for potential employees being conducted. DA #1 indicated meals were served hours late, and the DM has become more relaxed about the tray line start times. The ADM was interviewed on 8/3/21 at 2:02 PM, and she revealed meals were late on her first day of work, which was July 19th of this year, because a cook quit that day. She stated breakfast was served around 9:30-9:45 AM and lunch did not go out until 1:30 PM. The Administrator and a few nurses came to help with meal service on July 19th. During an interview with the DM on 8/3/21 between 1:01 PM and 1:23 PM, he revealed the dietary department has been struggling with short staffing and 3 staff are needed for each shift. Sometimes the DM and 1 Dietary Aide covered a shift. He stated if breakfast was late then that threw off the next few meals. A few weeks ago, on a Saturday, breakfast was served at 10:00 AM and the lunch line was started around 12:00 PM. He recalled the latest dinner was served at 8:00 PM. On 8/5/21 at 3:37 PM when asked about the late meals on 8/4/21, the DM stated the cook was running late and the ADM went into the kitchen and got things started. He arrived around 7:20 AM and he was the only DA on the line for breakfast. The DM stated tray line service for breakfast was started at 8:00 AM and it took 2 hours to get the breakfast line completed. He called in another DA, who came in around 12:00 PM. Lunch was delayed and the tray line was started around 2:00 PM, which took about an hour to complete. The Registered Dietitian (RD) was interviewed on 8/4/21 at 3:18 PM. She stated she was aware the dietary department was short staffed, and she provided support by entering data into the Minimum Data Set (MDS) as well as weights into the electronic medical record (EMR). She stated she has witnessed the Administrator helping in the kitchen during meal service and the corporate office provided a traveling cook at one time. On 8/4/21 at 12:29 PM, an interview was conducted with the Administrator. She revealed breakfast was late today because the DM a staff member call out and she was notified at 6:45 AM. Cook #1 was alone in the kitchen and the Administrator went to assist. She stated there have been dietary staffing challenges in the past and she has worked in the kitchen for several weeks. The Administrator further stated when a summer intern was in the facility, they spent a lot of time in dietary, along with other staff who have helped. She stated they have hired a cook and he did not show up, so the Administrator had to cook. All staff that have assisted in the kitchen have not received formal training. The Administrator indicated the latest meal delivery times occurred in July 2021, which were 9:30 AM for breakfast, 2:00 PM for lunch, and 8:00 PM for dinner. She stated these late mealtimes were unreasonable.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43222 Based on observation, record review, resident and staff interviews, the facility failed to serve food that was palatable and at an appetizing temperature to 4 of 7 sampled residents review for food palatability (Resident #s: 46, 55, 83 and 87). The findings included: 1. Interviews with residents on 8/1/21, revealed four of six residents interviewed voiced concerns about the temperature and taste of foods. a. Resident #46 was admitted to the facility 5/25/21. Diagnoses included dysphagia, gout and anemia. An admission Minimum Data Set (MDS) dated [DATE] assessed Resident #46 with clear speech, adequate hearing/vision, usually able to understand and be understood, cognitively intact, and required no staff assistance with eating. During an interview on 8/1/21 from 12:25 PM to 12:38 PM, Resident #46 stated the food was always cold and did not receive enough. When he tasted the meat portion of the lunch meal during the interview, he spit it out and stated it was lukewarm and tough. b. Resident #55 was readmitted to the facility 1/25/21. Diagnoses included diabetes, stroke, hypertension, and chronic kidney disease. A quarterly MDS dated [DATE] assessed Resident #55 with clear speech, adequate hearing/vision, able to be understood, understands others, intact cognition and fed herself but required supervision with 1 staff person assistance with meals. Resident #55 was interviewed on 8/1/21 at 01:51 PM and stated the food was always cold. She further stated she refused to eat cold food and would not ask staff to warm it up. c. Resident #83 was admitted to the facility 3/13/21. Diagnoses included diabetes, paraplegia, coronary artery disease and hyperlipidemia. A quarterly MDS dated [DATE] assessed Resident #83 with adequate hearing/vision, clear speech, understood by others, understands others, intact cognition, and was independent with eating. An interview with Resident #83 on 8/1/21 at 1:01 PM revealed the food was terrible, arrived late and cold. On 6/13/21, Resident #83 stated dinner arrived at 9:00 PM and the hamburger meat was raw. d. Resident #87 was readmitted to the facility 5/29/21. Diagnoses included dementia, heart failure, hypertension, and diabetes. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A quarterly MDS dated [DATE] assessed Resident #87 with intact cognition, clear speech, able to understand, able to be understood, adequate hearing/vision, and required limited assistance from staff with eating. An interview with Resident #87 on 8/1/21 at 1:51 PM revealed preferences were not fulfilled on meal tray after kitchen staff were notified and when asked for what they want instead, it takes a long time to receive. A test tray was requested on 8/3/21 at 12:41 PM for a regular lunch meal tray. The meal was plated at 12:43 PM with roasted potatoes, steamed spinach, and baked chicken. Iced tea and ice cream were included on the test tray. The CDM left the kitchen at 12:47 PM with the test tray and arrived on the South Hall at 12:47 PM. All residents on the South Hall were served by 12:58 PM and the test tray was sampled. Margarine and salt were added to the hot foods and the margarine remained congealed. The CDM and surveyors sampled the foods and observed the following: the chicken was without visible steam, while the roasted potatoes and spinach had visible steam. The CDM stated the chicken had good flavor but it could be hotter. The spinach tasted like spinach with no seasonings added and was warm. The potatoes had good flavor slightly warm but not hot. The iced tea had no ice and the CDM stated it usually has ice. During an interview with the Certified Dietary Manager (CDM) on 8/13/21 at 9:18 AM he stated he was not aware of the dietary complaints from the September or November 2020 Resident Council Meetings (RCM). The CDM indicated the Activities Director (AD) usually provided him with a grievance from any RCM with dietary issues. He was then required to correct the grievance in writing and give back to the AD. If a complaint came from a particular resident, then he would return the corrected grievance to the Social Worker. He stated he did not receive a grievance for either September or November 2020. When planning for the next meal of the month, the Resident Council president usually provided any feedback of the previous month's meal. The CDM stated she did not tell him about the dry ribs, and it has been several months since he received a grievance from the RCM. The Administrator stated in an interview on 8/5/21 at 3:07 PM that residents should receive foods served at acceptable taste/temperatures.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20934 Based on observation, staff and resident interviews and record review, the facility failed provide a therapeutic diet to 5 of 5 residents with a diet order for no potassium rich foods (Resident #51) and liberalized renal diet (a diet that recommends foods low in potassium and phosphorus) (Residents #31, #33, #34, #105). Spinach, a vegetable high in potassium and phosphorous was served to 4 residents with a diet order for a liberalized renal diet (Residents #31, #33, #34, #105) and a vegetable was not served to a resident (Resident #51) with a diet order for no potassium rich foods. The findings included: Review of the medical record revealed the following: 1a. Resident #31 was admitted to the facility on [DATE] with diagnoses to include end stage renal disease, among others. A diet order dated 3/1/21 recorded liberalized renal, no added salt diet, no water pitcher at the bedside. 1b. Resident #33 was readmitted to the facility on [DATE] with diagnoses to include end stage renal disease, among others. A diet order dated 7/30/21 recorded liberalized renal, large meat portions. 1c. Resident #34 was admitted to the facility on [DATE] with diagnoses to include end stage renal disease, among others. A diet order dated 10/20/20 recorded liberalized renal, large meat portion. 1d. Resident #51 was admitted to the facility on [DATE] with diagnoses to include end stage renal disease, among others. A diet order dated 11/2/20 recorded reduced concentrated sweets, no high potassium rich foods. 1e. Resident #105 was admitted to the facility on [DATE] with diagnoses to include end stage renal disease, among others. A diet order dated 2/23/21 recorded liberalized renal. During a continuous observation of the lunch meal tray line on 8/3/21 from 11:45 AM - 12:41 AM, the Assistant Dietary Manager (ADM) was observed to plate a 3-ounce portion of spinach for Residents #31, #33, #34, and #105 and Resident #51 did not receive a vegetable. There was no other vegetable available on the lunch meal tray line. Review of the lunch meal tray cards and Diet Report provided by the facility revealed Residents #31, #33, #34, and #105 received a liberalized renal diet and Resident #51 had a diet order for no potassium rich foods. Review of the therapeutic spreadsheet revealed green beans should be served as the vegetable to residents with a liberalized renal diet order or a diet order for no potassium rich foods. Green beans were not available on the lunch meal tray line. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the ADM occurred on 8/05/21 at 3:35 PM. The ADM stated that she was hired in her role two weeks ago and had not received formal training in this role. The ADM stated in her previous responsibilities as a dietary supervisor, she did not cook, so since she assumed her role as ADM, she had to ask questions because she had not been trained. The ADM stated that she did not review the therapeutic spreadsheet when she prepared the lunch meal that day (8/3/21) and did not notice that green beans was the alternate vegetable for residents with diet orders for no potassium rich foods or residents who received a liberalized renal diet. The ADM further stated that the green beans were not prepared and that this was an oversight. During an interview on 8/3/21 at 12:03 PM, the CDM stated that when the ADM was hired two weeks ago, she stated, I don't cook, and so far, she had only received a couple days of training with two of the cooks. He stated that the ADM had not yet trained with him and that she would need to have more days for training. The CDM further stated that he worked as the evening cook the day before, and therefore he was not in the kitchen to provide oversight for the lunch meal that day (8/3/21). He stated the ADM was filling in because the regular cook was off. The CDM stated that it was an oversight regarding the availability of green beans for residents with diet orders for liberal renal or no potassium rich foods. He stated that these residents should not receive spinach because it is rich in phosphorus and potassium. A telephone interview occurred with the consultant Registered Dietitian (RD) on 8/04/21 at 3:18 PM. The RD stated that she rounded at the facility every other week, reviewed/approved menus, and conducted monthly kitchen inspections. The RD further stated that she was not aware of dietary concerns related to items on the menu not being available, but that residents should receive foods according to their diet order.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20934 Based on observations, interviews with residents, family and staff and record review, the facility failed to provide meals on time according to the meal schedule. This had the potential to affect 106 of 108 residents. The findings included: 1a. A meal schedule was observed posted in the dining room on 8/1/21 at 12:40 PM. Meal delivery times were recorded as follows: Breakfast - 7:20 AM - 8:05 AM Lunch - 11:35 AM - 12:30 PM Dinner - 5:30 PM - 6:20 PM A telephone interview with a family member occurred on 8/1/21 at 11:44 AM. The family member stated that during a visit to the facility on [DATE] lunch was served to Resident #78 (cognition severely impaired per quarterly Minimum Data Set assessment dated [DATE]) between 2:00 PM - 2:30 PM and dinner on 7/12/21 was served to Resident #78 at 8:00 PM. Continuous observation of the lunch meal tray line occurred on 8/1/21 from 12:45 PM - 1:15 PM. The lunch meal tray line was observed in progress at 12:45 PM and ended at 1:15 PM. Continuous observations of meal delivery to residents on 8/1/21 revealed lunch meal carts were delivered to nursing units and then delivered to residents between 12:33 PM and 1:43 PM. A continuous observation of the lunch meal tray line occurred on 8/3/21 from 11:45 AM - 12:43 PM. During the observation, the lunch meal tray line stopped for the following: 11:53 AM for 11 minutes, to prepare/add steamed spinach to the tray line 12:14 PM for 9 minutes, to prepare/add pureed spinach to the tray line 12:30 PM for 10 minutes, to prepare/add steamed spinach to the tray line Resident meals were delivered on 8/3/21 to the nursing units and then to residents between 12:43 PM to 2:02 PM. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1b. A Resident Council meeting occurred on 8/2/21 at 3:00 PM. During the meeting 5 of 5 residents who attended (Residents #7, #43, #57, #63 and #75) stated that meals were usually delivered per the posted schedule, but depending on the staff available in the kitchen, at times meals were delivered late. Residents expressed that on Sunday, 8/1/21, they received all meals later than the meal schedule that was posted. The Certified Dietary Manager (CDM) stated in an interview on 8/3/21 at 1:23 PM that the tray line did not start on time which caused meals to be served late on Sunday, 8/1/21. He further stated that on Tuesday 8/3/21 meals were served late due to insufficient staffing and that staff did not prepare enough food, per the menu, which caused staff to stop the tray line to prepare more food. The CDM stated that the dietary department struggled with sufficient staff to carry out dietary services for several months and at times the dietary department operated with one cook and one dietary aide (DA) to prepare meals for 108 residents. He stated that if the breakfast meal was delivered late, that caused lunch and supper to also be served late. The CDM stated that a couple weeks ago on a Saturday (date unknown), breakfast was delivered to residents at 10:00 AM, lunch at 1:00 PM and dinner was delivered at 8:00 PM. He stated this also occurred on a holiday weekend in July 2021. The CDM further stated that meals were delivered to residents late a lot in the last few months. The CDM stated that as a result, his responsibilities included working as a cook, DA, putting away stock, ordering foods and interviewing staff to fill dietary vacancies. The CDM stated that for residents to receive meals delivered per the meal schedule, he needed 3 staff in his department on each shift. The CDM also stated that residents had expressed to him they were upset regarding receiving meals late and that he was aware of this concern voiced during Resident Council meetings. The Assistant Dietary Manager (ADM) was interviewed on 8/03/21 at 2:02 PM. The ADM stated that she was hired in her role three weeks ago and had not received formal training in this role. The ADM stated in her previous responsibilities as a dietary supervisor, she did not cook, so since she assumed her role as ADM, she had to ask questions because she had not been trained. The ADM stated that the dietary department was so short staffed since she started, there had not been anyone to train her. As a result, she relied on using the recipes, watching other staff, and asking questions. The ADM stated she prepared lunch that day (8/3/21) but because she had very little experience as a cook, she did not know how to calculate the amount of each food item necessary to feed 108 residents, so she did not prepare enough food which delayed the lunch meal because more food had to be prepared. The ADM recalled that on her first day of employment, 7/19/21, the cook quit that day which resulted in meals being served to residents late. The ADM stated that on that day (7/19/21) the first breakfast cart left the kitchen at 9:45 AM and the first lunch cart left the kitchen at 1:30 PM. During a telephone interview on 8/03/21 at 5:00 PM, Cook #1 stated that in the 2 weeks he was employed by the facility, meals were about 25 minutes late leaving the kitchen. He further stated that this occurred twice because the pureed bread or the alternate soup had not been prepared. He stated that the staff had to stop the tray line to prepare items that were forgotten. Cook #1 stated that these errors occurred when the dietary department was short staffed having only a cook and a DA to prepare the meal. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 8/04/21 at 12:29 PM with the Administrator and Director of Nursing (DON). The interview revealed that on 8/4/21, the breakfast meal was served late due to dietary staff call out. The Administrator stated that she was notified on 8/4/21 at 6:45 AM, that Cook #1 was in the kitchen alone. The Administrator stated that she went to the kitchen to assist. She stated that due to repeated staffing challenges in the dietary department, she provided regular dietary assistance for the past several weeks and daily for a while during the summer months. The Administrator further stated that assisting in the dietary department was a team effort because applicants to that department either did not pass the background check, the drug test, or had no formal training. She stated that due to staffing challenges mealtimes were impacted and that for 2 weeks in July 2021 there were times that breakfast was served as late as 9:30 AM, lunch as late as 2 pm, and dinner as late as 8:00 PM. The Administrator stated she was aware that residents felt that the quality of foods was affected due to the timeliness of meals. Additionally, the Administrator stated that serving lunch at 2:00 pm was not reasonable neither was serving dinner at 8:00 PM. She stated that dinner should be served earlier. The consultant registered dietitian (RD) was interviewed by phone on 8/04/21 at 3:18 PM. The RD stated that she provided clinical support to the facility and she was aware of the facility's staffing challenges. As a result, she began providing support with dietary assessments and entering weight data into resident's electronic records. The RD stated that the CDM worked long hours to cover shifts and that she also observed the Administrator assisting in the kitchen. The RD further stated that the corporate office provided a traveling cook only once for support, and that the primary corporate role was clinical support.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 20934 Based on observation, staff interview and review of records, the facility failed to 1) maintain milk, a potentially hazardous food, 41 degrees Fahrenheit (F) or below on the lunch meal tray line, 2) discard potentially hazardous foods with signs of spoilage (iceberg lettuce, bell peppers, bananas), 2) label and date opened food items (turkey breast, deli ham), 3) store foods in a closed container (vegetable beef soup) and 4) store bananas 56 - 60 degrees Fahrenheit (F) per manufacturer recommendations. This occurred in 1 of 1 refrigerator, freezer, and dry storage. The findings included: 1a. A continuous observation of cold storage (walk in refrigerator and freezer) and dry storage occurred on 08/01/21 from 1:01 PM to 1:39 PM and revealed the following: The walk-in refrigerator was observed with: -An unopened clear plastic bag of crisp head lettuce (Iceberg) with brown leaves surrounded by a dark brown liquid substance. -An opened package of deli turkey breast, unwrapped, stored in a box with an illegible date recorded on the package and surrounded by an opaque liquid substance. -An opened package of deli ham was wrapped in plastic and stored in a box with the date 6/24/21 recorded on the box. The deli ham did not have a date of opening recorded on the package. -The freezer was observed with a 4-pound plastic container of vegetable beef soup that was stored with a plastic cover that was unsealed; the soup was open to air. -A case of bananas was observed stored on the lower shelf of the cook's prep table. All the bananas were covered with large brown/black spots. Manufacturer instructions recorded on the box to store the bananas 56 - 60 degrees F. 1b. During a continuous kitchen observation on 8/3/21 from 11:33 AM to 12:07 PM, the following was noted: -At 11:33 AM, dietary staff removed a plastic container from refrigeration filled with 8-ounce cartons of milk in a pool of water which was placed on the lunch tray line. -At 11:37 AM, the Assistant Dietary Manager (ADM) monitored the temperature of the milk and obtained a temperature of 46 degrees F. The milk temperature was communicated to the Certified Dietary Manager (CDM) and he stated that the milk was just delivered. -At 11:45 AM, the lunch meal tray line began, and 2 cartons of milk were placed on meal trays for delivery to residents. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 12:07 PM, staff pushed the cart towards the door for delivery to residents. Staff confirmed that the cart was ready for delivery. -At 12:07 PM, temperature monitoring of the milk was requested by the surveyor and a temperature of 49 degrees F was obtained by the ADM. The CDM stated, it's gone up and instructed staff not to serve any of the milk. During an interview with the CDM on 8/1/21 at 1:39 PM, he stated that food storage was monitored twice weekly when stock was delivered. He stated that he received a delivery on Friday, 7/30/21 but he was also the cook and dishwasher that day, so he did not get a chance to check food storage for items that needed to be discarded or labeled. He confirmed that the lettuce and bell peppers showed signs of spoilage and should have been discarded, all opened foods should be stored labeled/dated, and all foods should be stored in a closed container. An interview on 8/01/21 at 2:56 PM with the Maintenance Director revealed the current ambient temperature in the dietary department was 74 - 75 degrees F. A follow up interview and observation of the kitchen on 8/3/21 at 1:23 PM revealed a case of bananas with large brown/black spots was stored on the lower shelf of the cook's prep table. The CDM stated that bananas were typically stored on the lower shelf of the cook's prep table. He further stated that he was not aware of the manufacturer recommendations recorded on the box to store bananas 56 - 60 degrees F and he was not aware that the current ambient temperature in the kitchen was 74 - 75 degrees. He also stated that he did not order enough milk with the last order to last until the lunch meal on 8/3/21. He stated that milk was delivered on 8/3/21 shortly after 11:00 AM and by the time he was able to put the stock away the milk was not refrigerated long enough to be served 41 degrees or below for the lunch meal that day (8/3/21). The CDM further stated that at the time staff identified the milk temperature of 46 degrees F, he should have directed staff not to serve the milk. The Administrator was interviewed on 8/4/21 at 12:29 PM and stated that all food items should be monitored for signs of expiration, stored covered and labeled with a date of storage. She further stated that produce should be stored according to manufacturer's recommendations and milk should be kept in refrigeration at 41 degrees or below.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37014 Based on observations, record review and staff interviews, the facility failed to maintain an accurate Medication Administration Record (MAR) for the administration of oxygen no longer in use for 1 of 1 resident reviewed for respiratory care (Resident #72). Findings included: Resident #72 was admitted to the facility on [DATE] with diagnoses that included congestive heart failure and asthma. The quarterly Minimum Data Set (MDS) dated [DATE] assessed Resident #72 with intact cognition for daily decision making. The MDS noted Resident #72 received oxygen therapy while a resident. Review of Resident #72's July 2021 Medication Administration Record revealed a physician's order dated 12/17/20 for oxygen at 2 Liters Per Minute (LPM), continuous. Further review noted the order was initialed on the MAR as administered daily at 6:30 AM, 2:30 PM and 10:30 PM. Observations conducted of Resident #72 on 08/01/21 at 12:50 PM, 08/03/21 at 9:00 AM, 08/03/21 at 4:33 PM and 08/05/21 at 9:30 AM revealed no supplemental oxygen in use. During an interview on 08/01/21 at 12:50 PM, Resident #72 stated she did not use supplemental oxygen. An interview was conducted with Nurse #4 on 08/05/21 at 9:33 AM who was frequently assigned to provide Resident #72's care. Nurse #4 reviewed Resident #72's current MAR and confirmed there was an active physician's order for continuous oxygen at 2 LPM and stated Resident #72 did not use supplemental oxygen. Nurse #4 could not explain why she had initialed the order on the MAR as completed and stated she had done so in error. An interview and subsequent observation of Resident #72 were conducted with the Nursing House Supervisor (NHS) on 08/05/21 at 9:40 AM. The NHS reviewed Resident #72's current MAR and confirmed she had an active physician's order for continuous oxygen at 2 LPM. Upon observation, Resident #72 was lying in bed and appeared to be resting comfortably. The NHS verified Resident #72 had no oxygen in use and stated she showed no signs of respiratory distress or trouble breathing while on room air. The NHS could not explain why there was a physician's order for Resident #72 to receive continuous oxygen or why nursing staff had initialed oxygen was administered daily on Resident #72's MAR. He added the physician should have been notified that Resident #72 did not receive continuous oxygen so that the order could be discontinued. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Administrator was conducted on 08/05/21 at 9:42 AM. The Administrator explained Resident #72 may have used supplemental oxygen earlier in the year but had not used any for a while. The Administrator stated she had noticed Resident #72's order for continuous oxygen when she completed the 6:30 AM medication pass on 07/29/21 and initialed the MAR as not administered with the intention of notifying the Medical Director (MD) for the order to be discontinued since it was not in use. She could not explain why nursing staff continued to initial the order for oxygen as administered daily on Resident #72's MAR and stated they should have notified the MD for the order to be discontinued since it was no longer in use by Resident #72. A telephone interview was conducted with the MD on 08/06/21 at 9:26 AM. The MD stated the pharmacy was usually good to inform him of orders that needed to be discontinued, especially when there was an order for continuous oxygen that the resident was not using. The MD did not recall being notified by anyone that Resident #72 was not using supplemental oxygen and stated he would have liked to have known so that the order could be discontinued.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39037 Based on observations, record review, and staff interviews the facility failed to implement their infection control policies and the Center for Disease Control and Prevention (CDC) guidelines for the use of Personal Protective Equipment (PPE) when 1 of 1 housekeepers (Housekeeper #1) failed to wear an N-95 mask, eye protection, and a gown when mopping the floor of 1 of 1 resident (Resident #309) reviewed for Enhanced Droplet Precautions, failed to place a Contact Isolation sign on the door of 1 of 3 residents reviewed for infection control (Resident #22), failed to perform hand hygiene during dressing changes for 1 of 4 residents (Resident #44) reviewed for pressure ulcers, 1 NA (NA #8) failed to perform hand hygiene before delivering a meal tray and handled food with her bare hands for meals being served on 1 of 3 halls, and 2 dietary staff members (Cook #1 and Dietary Aide #1) failed to wear a face mask covering their nose and mouth for 2 of 4 dietary staff reviewed for appropriate PPE use. These failures occurred during a COVID-19 pandemic. The findings included: 1. Review of the facility's policy titled COVID-19 Response Guidelines last updated 06/16/21 read in part: PPE for New Admission Area A. Health Care Personnel (HCP) should wear an N-95 or higher-level respirator, eye protection (i.e., goggles or a face shield that covers the front and sides of the face), gloves, and gown when caring for those residents. The CDC guidance entitled, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated 02/23/21 indicated in part the following statements under the section Recommended infection prevention and control (IPC) practices when caring for a patient with suspected or confirmed SARS-CoV-2 infection: The PPE recommended when caring for a patient with suspected or confirmed COVID-19 includes the following: Respirator -Put on an N-95 respirator (or equivalent or higher-level respirator) before entry into the patient room or care area Eye Protection -Put on eye protection (i.e. goggles or a face shield that covers the front and sides of the face) upon entry to the patient room or care area. Gloves -Put on clean, non-sterile gloves upon entry into the patient room or care area. Gowns (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Put on a clean isolation gown upon entry into the patient room or area. Change the gown if it becomes soiled. Remove and discard the gown in a dedicated container for waste or linen before leaving the patient room or care area. 1. An observation of the open door of room [ROOM NUMBER] on 08/01/21 at 10:57 AM revealed a sign stating Resident # 309 was on Enhanced Droplet Isolation and any person entering the room was to wear an N-95 mask, perform hand hygiene, put on eye protection, put on a gown, and put on gloves before entering the room. Housekeeper #1 was observed at the same date and time to be standing in front of room [ROOM NUMBER] with her housekeeping cart wearing only a surgical mask. An interview with Housekeeper #1 on 08/01/21 at 10:58 AM revealed she had just finished mopping under Resident #309's feet due to Resident #309 reporting the floor was sticky under her feet. Housekeeper #1 stated she only wore a surgical mask and gloves while mopping Resident #1's room. She explained she had been trained to use an N-95 mask, goggles, a gown, and gloves before entering any room with an Enhanced Droplet Isolation sign in place but all she had readily available was the surgical mask she had been wearing since the beginning of her shift and gloves from her housekeeping cart. She explained there were usually N-95 masks, goggles, gowns, and gloves on a cart in the hall but she did not see a cart with those supplies and she was afraid Resident #309 might stand up and fall because the floor was sticky so she went ahead and mopped the floor wearing only her surgical mask and gloves. An interview with Nurse #3 on 08/01/21 at 11:14 AM revealed Resident #309 was on Enhanced Droplet Isolation because she was a new admission and any person entering room [ROOM NUMBER] was to put on PPE including an N-95 mask, goggles, a gown, and gloves before entering the room. Nurse #3 stated carts containing needed Personal Protective Equipment (PPE) were usually in the halls and there was probably a cart farther up the hall on the other side of the building. An interview with the Director of Nursing (DON) on 08/01/21 at 03:42 PM revealed all newly admitted residents who were not vaccinated or had an unknown vaccination status were placed on Enhanced Droplet Precautions for 14 days and any person entering a resident room with a sign indicating that type of isolation should be wearing the PPE described on the sign. An interview with the Housekeeping Supervisor on 08/05/21 at 01:37 PM revealed housekeeping personnel were expected to wear the PPE described on posted signage when working in isolation rooms. The Housekeeping Supervisor stated she had done in-services with housekeeping staff on what PPE to wear in isolation rooms and where to obtain additional PPE supplies if supplies ran out. She stated the housekeeping department was also included in facility in-services regarding PPE use in isolation rooms. An interview with the Administrator on 08/05/21 at 06:15 PM revealed Resident #309's vaccination status was unknown at the time of admission and that's why she was placed on Enhanced Droplet Precautions. She further stated the facility had plenty of PPE supplies and all staff entering isolation rooms should be wearing the type of PPE indicated on the sign. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. Building B. Wing	08/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saturn Nursing & Rehabilitation	1930 West Sugar Creek Road Charlotte, NC 28262

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of the facility's policy titled Isolation-Categories of Transmission-Based Precautions last updated 01/2018 read in part: Transmission-Based Precautions are initiated when a resident develops signs and symptoms of a transmissible infection or has a laboratory confirmed infection and is at risk of transmitting the infection to other residents. When a resident is placed on transmission-based precautions, appropriate notification is placed on the room entrance door so that personnel and visitors are aware of the need for and the type of precautions. Contact precautions may be implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. The individual on contact precautions will be placed in a private room if possible. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #22 had an indwelling catheter (a tube that drains urine out of the bladder). A urine culture (a test to see if bacteria are growing in the urine) dated 07/29/21 revealed Resident #22 was growing Escherichia coli (abbreviated as E-coli and meaning a type of bacteria) extended spectrum beta lactamase (Abbreviated as ESBL and meaning an enzyme which makes treating bacteria with antibiotics more difficult. ESBL bacteria can be spread from person to person on the contaminated hands of residents and caregivers. Transmission risk can be increased if the person has a catheter). An observation of the door to Resident #22's room on 08/01/21 at 12:30 PM revealed no posted signage indicating Resident #22 was on isolation. An interview with Nurse #3 on 08/01/21 at 12:36 PM revealed Resident #22 had been moved to her current room on 07/30/21 so she could have a private room and would not have to share a bathroom with other residents due to ESBL in her urine. Nurse #3 stated she hadn't noticed there was no isolation sign on Resident #22's door. She stated carts containing needed Personal Protective Equipment (PPE) were usually in the halls and there was probably a cart farther up the hall on the other side of the building. An observation of the door to Resident #22's room on 08/01/21 at 01:08 PM revealed no signage was posted indicating Resident #22 was on isolation. An interview with Unit Manager #1 on 08/01/21 at 03:17 PM revealed Resident #22 had been moved to her current room on 07/30/21 so she could have a private bathroom due to growing ESBL in her urine. Unit Manager #1 stated Resident #22 should have had an isolation sign posted on her door when she was moved to a private room on 07/30/21 and she thought the Staff Development Coordinator (SDC) was responsible for placing the appropriate isolation sign on Resident #22's door. She explained the SDC was not working on 08/01/21 and was not sure why an isolation sign was not posted on Resident #22's door on 08/01/21. Unit Manager #1 stated she was not sure which type of isolation Resident #22 should have been placed on after her urine culture results returned. An observation of the door to Resident #22's room on 08/01/21 at 03:28 PM revealed no isolation sign was posted on her door. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the Director of Nursing (DON) on 08/01/21 at 03:42 PM revealed Resident #22 should have had a sign on her door indicating she was on Contact Isolation. She explained Contact Isolation meant any person entering Resident #22's room should wear a gown and gloves before entering and discard the gown and gloves and perform hand hygiene before leaving the room. The DON stated the isolation sign should have been placed on her door when she was moved a private room on 07/30/21. She stated the nurse on the hall, unit managers, or herself could have placed the Contact Isolation sign on the door of Resident #22's room when she was moved and was not sure why a Contact Isolation sign had not been placed on her door. An interview with the Administrator on 08/05/21 at 06:15 PM revealed a Contact Isolation sign should have been placed on the door to Resident #22's room when she was moved to the private room and the reason it was not was due to human error. An interview with the Physician on 08/06/21 at 09:26 AM revealed Resident #22 should have been placed on Contact Isolation when she was diagnosed with ESBL growing in her urine. 3. Review of the facility's policy titled Procedure: Infection Control Precautions for Dressing Changes, Clean Procedures, and Using the Treatment Cart last updated in 2019 read in part as soon as you have finished removing the soiled dressing and cleansing the wound, remove and discard your gloves. Wash your hands (or use an alcohol cleanser) after removing and discarding the existing dressing. A continuous observation of Nurse #9 on 08/02/21 at 02:15 PM revealed she applied betadine to Resident #44's right heel, discarded soiled gloves, and applied clean gloves without performing hand hygiene after removing soiled gloves. Nurse #9 cleaned the wound to Resident #44's right calf, applied dakin's soaked gauze, covered the wound with a dry dressing, and removed soiled gloves. Nurse #9 then applied clean gloves without performing hand hygiene after removing soiled gloves, and removed the dressings to Resident #44's left and right ischium and sacrum. She cleaned the wounds and removed soiled gloves. Nurse #9 applied gloves without performing hand hygiene after removing soiled gloves, packed the left and right ischial wounds. She removed her soiled gloves and reapplied clean gloves without performing hand hygiene in between removing soiled gloves and applying clean gloves, packed the sacral wound, and covered the left and right ischial and sacral wounds with a dry dressing. An interview with Nurse #9 on 08/02/21 at 03:56 PM revealed she should have performed hand hygiene after removing soiled gloves and before applying clean gloves and she did not perform hand hygiene because it was an oversight. An interview with the Administrator on 08/05/21 at 06:15 PM revealed staff should always perform hand hygiene after removing soiled gloves and before applying clean gloves. A facility education titled COVID update, Infection Control, PPE (personal protective equipment), Handwashing, and Mask Wearing Correctly, on 7/27/2021 was reviewed. CDC guidance titled How to Wear Masks, dated 6/11/2021 was reviewed. It read in part: Put the mask over your nose and mouth and secure it under your chin. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. An observation was completed on 8/3/2021 at 12:53 PM of Nurse Aide #8 delivering a lunch meal tray to room [ROOM NUMBER]A without proper hand hygiene. She was observed opening condiments and then opened a sandwich contained in plastic wrap with her bare hands. Nurse Aide #8 then put the contents of the condiment packets on either side of the open sandwich, opened the silverware pouch and cut the sandwich with a knife. She put a straw in a beverage then washed her hands in bathroom. An interview was completed with Nurse Aide #8 at the time of the observation. She explained she washed her hands in the break room before passing out any trays on the hall. She stated she could not provide a reason why she did not perform hand hygiene in between resident meal trays. Review of Nurse Aide #8's education record revealed she received training on 7/27/2021 related to hand hygiene. An interview was completed on 8/5/2021 at 9:09 AM with the Administrator, who also served as one of the Infection Preventionists. She stated hand hygiene should be performed before serving or when touching items on meal trays. 5. An observation of the Dietary Department was completed on 8/1/2021 at 12:48 PM which revealed two (2) dietary staff not wearing face masks covering their nose and mouth while working in the kitchen. Cook #1 was wearing a soiled face mask below his nose and Dietary Aide (DA) #1's face mask was below her chin. An additional observation on 8/3/21 at 11:05 AM of DA #1 was completed of her face mask below her nose. A phone interview was completed with Cook #1 on 8/3/2021 at 5:00 PM. He explained his mask comes down and he tries to keep it up, but it gets hot in the kitchen. He revealed he had been trained on infection control and Covid-19 inclusive of wearing a mask at all times. Review of Cook #1's education record revealed he received training on 7/27/2021 related to mask usage. A phone interview was completed on 8/5/2021 at 11:20 AM with Dietary Aide (DA) #1 who stated she had not received any recent in-person training on infection control and Covid-19 inclusive of wearing a mask at all times. She stated the only infection control training she received was back in March 2020 when COVID was first announced and some online training since then. DA #1 voiced she moved the mask below her nose during tray line when calling out orders to the cook, other than that she wore the face mask properly. Review of Dietary Aide #1's education record revealed she received training on 7/27/2021 related to mask usage. An interview was completed on 8/3/2021 at 1:23 PM with the Dietary Manager (DM) who revealed staff are expected to always have a mask on that covers the nose and mouth. He stated he told DA #1 to cover her nose with her face mask. An interview was completed on 8/5/2021 at 9:09 AM with the Administrator, who also served as one of the Infection Preventionists. She stated face masks should be worn correctly while in the facility.