| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345045 | A. Building<br>B. Wing | 07/03/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| The Foley Center at Chestnut Ridge | 621 Chestnut Ridge Parkway<br>Blowing Rock, NC 28605 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38515<br><br>Based on record review and staff interviews, the facility failed to treat a resident with dignity and respect when a nurse aide was witnessed with her hand raised to a cognitively impaired resident's face during an interaction in the resident's room for 1 of 4 residents reviewed for dignity (Resident #41). A reasonable person would not like someone raising a hand in front of their face.<br><br>The findings included:<br><br>Resident #41 was admitted to the facility on [DATE].<br><br>Review of Resident #41's quarterly Minimum Data Set assessment dated [DATE] revealed Resident #41 was moderately cognitively impaired.<br><br>Review of facility provided allegations of abuse, neglect, or misappropriation revealed Resident #41 was involved in an altercation with Nurse Aide #10 on 01/27/24 in which Nurse Aide #11 heard shouting coming from Resident #41's room and when she arrived, she witnessed Nurse Aide #10 and Resident #41 standing close together and face to face with Nurse Aide #10's hand raised in the air toward Resident #41's face.<br><br>An interview with Nurse Aide #11 on 06/27/24 at 2;56 PM revealed she was working the evening of 01/27/24 and late in the evening, she heard shouting coming from Resident #41's room. Nurse Aide #11 reported she went to the room and when she walked into the room, she observed Nurse Aide #10 and Resident #41 standing face to face and Nurse Aide #10 had her right arm raised and indicated by the time she got to the room no one was shouting. She stated the way Nurse Aide #10's arm was raised she felt that Nurse Aide #10 was possibly going to put her hand over Resident #41's mouth or potentially strike her. Nurse Aide #11 reported she did not observe Nurse Aide #10 strike Resident #41 or cover her mouth but did ask Nurse Aide if she needed her to take over, to which Nurse Aide #10 replied no and then left the room. Nurse Aide #11 stated she stayed with Resident #41 who did not appear to be upset and then went and told her hall nurse what she had observed, though she could not recall her name. Nurse Aide #11 stated she also could not recall if Nurse Aide #10 worked the rest of her shift or not.<br><br>An interview with Resident #41 was completed on 06/27/24 at 4:47 PM. Resident #41 had no recollection of the event and stated she felt safe at the facility. Resident #41 did not report any issues or concerns at that time.<br><br>(continued on next page) |

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

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

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of facility provided schedules revealed Nurse #8 was assigned as the hall nurse the night of the incident.<br><br>Multiple attempts to reach Nurse #8 by telephone were unsuccessful.<br><br>Multiple attempts to reach Nurse Aide #10 by telephone were unsuccessful.<br><br>Additional review of the facility's investigation into the incident revealed Nurse Aide #10 did not provide a written statement regarding the incident.<br><br>An interview with the Administrator on 06/28/24 at 1:28 PM revealed she was the facility's abuse coordinator and that she remembered the incident and stated it was her understanding that Nurse Aide #11 observed Nurse Aide #10 raise her hand in the face of Resident #41. The Administrator reported Nurse Aide #10 was terminated and followed up by stating she expected her staff to treat all residents in the facility with respect and dignity, even if the resident was being difficult. She indicated Nurse Aide #10 should have removed herself from the situation and returned at a later time if Resident #41 was having a difficult moment instead of becoming confrontational. |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50045<br><br>Based on record review, staff interview, and Nurse Practitioner (NP) interviews the facility failed to ensure a resident's code status election was accurate throughout the medical record for 1 of 4 residents reviewed for advanced directives (Resident # 57).<br><br>The findings included:<br><br>Resident #57 was admitted to the facility on [DATE] with a diagnosis of adult failure to thrive.<br><br>A quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #57 was cognitively intact.<br><br>A review of a care plan dated [DATE] revealed Resident #57 had an unspecified advanced directive in place and his wishes were to be honored.<br><br>A review of the advanced directives book at the nurse's station conducted on [DATE] at 3:46 pm revealed Resident #57 had a Do Not Resuscitate (DNR) form dated [DATE] and was signed by the MD and a Medical Orders for Scope of Treatment (MOST) form dated [DATE] revealed Resident #57 wanted CPR and full scope of treatment and was signed by the MD.<br><br>A review of a physician's order dated [DATE] revealed Resident #57 wanted to receive Cardiopulmonary Resuscitation (CPR, chest compressions to restart the heart) with limited interventions.<br><br>During an interview on [DATE] at 2:15 PM Resident #57 stated he wanted to be a full code with a full scope of treatment.<br><br>An interview was conducted on [DATE] at 2:10 pm with Nurse Supervisor #1. Nurse Supervisor #1 stated when a resident was admitted to the facility, the Nurse on the hall reviewed the DNR and MOST forms with the resident and would complete the form. The completed forms were then given to a Nurse Supervisor, placed in the provider book, signed by the provider, and placed in the advanced directives book at the appropriate nurse's station. The hall nurse/admission nurse was responsible for entering the appropriate code status order in the Electronic Medical Record (EMR) if known at the time of admission. Nurse Supervisor #1 stated Resident #57 had an order for a full code. Nurse Supervisor #1 stated she was unsure of why there was a MOST form indicating full code with full scope of treatment and a DNR dated the same day. Nurse Supervisor #1 stated the advanced directives should match and reflect the resident's wishes. Nurse Supervisor #1 was not able to identify who completed the forms and stated it must have been overlooked.<br><br>An interview was conducted on [DATE] at 2:17 pm with the Medical Records Coordinator. The Medical Records Coordinator reported she had just transitioned to that role and had only completed 4 days of orientation. The Medical Records Coordinator stated she had to collect the MOST and DNR forms and scan them into the Electronic Health Record (EHR) and place the documents in the advanced directives book at the appropriate nurse's station. The Medical Records Coordinator stated Resident #57's MOST form should reflect his wishes and a resident should not have a DNR with a MOST form indicating full code with a full scope of treatment.<br><br>(continued on next page) |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An interview was conducted on [DATE] at 2:18 pm with the Admission Coordinator. The Admission Coordinator stated she enters the resident's code status, if known, into the EHR on admission. The Admission Coordinator reported she did not complete the DNR or MOST form and stated that both forms were in the admissions packet to be completed by the hall/admissions nurse.<br><br>An interview was conducted on [DATE] at 11:33 am with the Nurse Practitioner (NP). The NP stated on admission the admissions nurse would go over and complete the MOST and DNR forms with the resident and their family. The NP stated during an initial visit with a resident, she would go over resident's code status information and verify the MOST/DNR forms at that time. The NP stated the MOST form and DNR should reflect the resident's wishes. The NP stated that Resident #57's MOST form should not indicate he was a full code with a full scope of treatment if he wanted to be a DNR and vice versa. The NP said that was an error. The NP stated the admission packets had a DNR and MOST form. The NP stated it was not uncommon for both forms to be left completed on her desk and could have easily been looked over by the provider when signing admission paperwork.<br><br>An interview was conducted on [DATE] at 11:37 am with the Social Worker (SW). The SW stated she was not responsible for completing the MOST and DNR forms when a resident was admitted . The SW stated if a resident had a Health Care Power of Attorney (HCPOA) or a living will, she would obtain copies on admission. The SW stated Resident #57 wanted to be a full code and should not have had a signed DNR form in the advanced directives book at the nurse's station.<br><br>An interview was conducted on [DATE] at 12:13 pm with the Interim Director of Nursing (DON). The Interim DON verified the hall/admissions nurse was responsible for completing the MOST and DNR forms according to the resident's wishes. The Interim DON stated she had been made aware of Resident #57 having a MOST form indicating full code and full scope of treatment and a signed DNR form. The Interim DON stated that was an error and Resident #57 wished to be a full code. |

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| F 0580<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50045<br><br>Based on record review, staff, Social Worker (SW), Nurse Practitioner (NP), and Medical Director (MD) interviews the facility failed to notify a medical provider when Resident #278 was noted by Medication Aide (MA) #1 to have difficulty breathing, had an oxygen saturation in the high 70's/low 80's (normal oxygen saturation is 92 to 100%), and was asking for help. On [DATE] at 7:00 am MA #1 was told by Nurse #2 that Resident #278 was having issues with breathing. MA #1 checked Resident #278 and noted an oxygen saturation in the high 70's/low 80's, and got the Director of Nursing (DON). The DON advised MA #1 to place Resident #278 on oxygen and continue to monitor her oxygen saturation levels. MA #1 reported Resident #278's oxygen saturation levels remained in the 80's and she appeared to be struggling to breathe and was asking for help. MA #1 continued to report breathing issues and concern about Resident #278 throughout the shift to the DON until Resident #278 was removed from the facility on [DATE] at 4:47 pm by Resident #278's Representative (RR). The RR took Resident #278 to the Emergency Department where Resident #278 was diagnosed with Influenza A (the flu) Influenzal Bronchitis (inflammation of the airway), had an elevated white blood cell count (which indicated infection), and was given intravenous fluids, steroids (used to decrease inflammation), a breathing treatment, and was admitted to the hospital. Resident #278 was later diagnosed with acute hypoxemic respiratory failure and was placed on comfort measures on [DATE], received inpatient hospice services in the hospital and expired on [DATE]. The certificate of death revealed Resident #278's immediate cause of death was acute hypoxemic respiratory failure, Influenza A, and bacterial pneumonia. The deficient practice was identified for 1 of 3 residents reviewed for notification of change in condition (Resident #278).<br><br>Immediate jeopardy began on [DATE] when Resident #278's was noted to have an oxygen saturation level in the high 70's/low 80's by MA #1 and the physician was not notified. Immediate jeopardy was removed on [DATE] when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity of D (no actual harm with a potential for minimal harm that is not immediate jeopardy) to ensure education is completed and monitoring systems put into place are effective.<br><br>The findings included:<br><br>Resident #278 was readmitted to the facility on [DATE] with a diagnosis of heart disease.<br><br>A review of a Medical Orders for Scope of Treatment (MOST) form dated [DATE] revealed Resident #278 was a full code and wished to receive all medical interventions including intubation, advanced airway interventions, mechanical ventilation, cardioversion (a procedure using electricity and medications to convert the heart from an irregular to a regular rhythm) as indicated, medical treatment, intravenous fluids, and to be transferred to the hospital if indicated.<br><br>A review of a care plan dated [DATE] revealed Resident #278 had an advanced directive in place and her wishes were to be honored.<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | A telephone interview was conducted on [DATE] at 7:30 pm with MA #1. MA #1 reported she worked on [DATE] during dayshift (7:00 am to 7:00 pm) and was assigned Resident #278. MA #1 stated she received a report from Nurse #2 at 7:00 am and was told by Nurse #2 that Resident #278 was not doing well. MA #1 reported she immediately checked on Resident #278 at 7:00 am and noticed Resident #278 was struggling with breathing and asking for help. MA #1 reported she obtained an oxygen saturation level in the low 70's/high 80's but was unable to recall the exact result. MA #1 stated she immediately got the DON and was instructed to place Resident #278 on oxygen and to continue checking oxygen saturation levels. MA #1 was not able to recall the DON performing an assessment. MA #1 reported she placed Resident #278 on oxygen; however, she was unable to recall the exact liters/minute and routinely checked Resident #278's oxygen level throughout the shift. MA #1 reported she had not recalled Resident #278's oxygen level rising above 90%. MA #1 stated she repeatedly told the DON about Resident #278 struggling to breathe, low oxygen saturation levels, and how she felt Resident #278 needed to be sent to the hospital throughout the shift, but no one would listen to her. MA #1 reported she had not called the provider, because she had communicated concerns to the DON. MA #1 stated she continued to check Resident #278's oxygen saturation often but was unable to recall getting a full set of vital signs.<br><br>A review of the February 2024 Medication Administration Record (MAR) revealed no documented vital signs.<br><br>An attempt was made to contact Nurse #2 on [DATE] and was unsuccessful.<br><br>The DON was unavailable for an interview.<br><br>A review of a progress note dated [DATE] at 4:47 pm written by the Social Worker (SW), revealed Resident #278 RR came to the facility on [DATE] and the Resident Representative (RR) removed Resident #278 from the facility. The SW asked the RR to take an oxygen tank with them due to Resident #278's oxygen levels had been falling at times, but they refused and stated they were going straight to the emergency room from the facility and declined the offer.<br><br>An interview was conducted on [DATE] at 2:10 pm with the SW. The SW reported on [DATE] a conversation was had between the Administrator and the RR, and the RR arrived at the facility upset and removed Resident #278 from the facility. The SW reported that when the RR arrived, she went to the room with her to pack up Resident #278's belongings. The RR stated Resident #278 was really sick and they were going to take her straight to the Emergency Department. The SW stated Resident #278 had been having respiratory issues and had received treatment for respiratory symptoms. The SW recalled MA #1 was in the process of calling the on-call medical provider when the RR arrived due to concern over Resident #278's breathing and was concerned that the respiratory issues had progressed to pneumonia. The SW stated she informed the RR that MA #1 was calling the MD, but the RR insisted on removing Resident #278 from the facility anyway. The SW stated she offered the RR an emergency oxygen tank to take with them for their drive to the hospital and the RR refused.<br><br>A follow-up interview was conducted on [DATE] at 11:41 am with the SW. The SW reported she had walked down 400 hall and remembered MA #1 stating Resident #278 was not doing very good and did not look good around lunch time, 11:30 am. The SW stated she asked MA #1 if she had notified anyone. The SW stated she went in the room at 11:30 am and observed Resident #278 on oxygen and stated she looked sick. The SW stated after she left the room, she immediately went to get the DON and was met near the front entrance of the facility by the RR.<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | An interview was conducted on [DATE] at 3:57 pm with Nurse Supervisor #1. Nurse Supervisor #1stated she worked on [DATE]. Nurse Supervisor #1 reported she had not gone to assess Resident #278 because she was never informed by MA #1 that Resident #278 was having difficulty breathing. Nurse Supervisor #1 stated she had not notified the NP because she was not aware Resident #278 had low oxygen saturation levels or difficulty breathing at that time.<br><br>An interview was conducted on [DATE] at 4:40 pm with Nurse Supervisor #2. Nurse Supervisor #2 reported she had worked with Resident #278 a few times and remembered that she had been lying in bed more often and she had a cough. She stated Resident #278 was tested for Influenza and COVID at the facility, however she was not able to locate the Influenza results. Nurse Supervisor #2 stated if Resident #278 had been having upper respiratory infection symptoms, nursing assessment should have been completed. Nurse Supervisor #2 reported if Resident #278 had a change in condition, low oxygen saturation levels, or respiratory distress a provider should have been notified.<br><br>An interview was conducted on [DATE] at 11:12 am with the NP. The NP reported she had seen Resident #278 on [DATE] at which time Resident #278 had a cough and congestion. The NP stated she never received any additional notification that Resident #278 had continued to have respiratory issues.<br><br>A telephone interview was conducted on [DATE] at 4:16 pm with the MD. The MD stated he was not aware that Resident #278 had been taken to the Emergency Department on [DATE] after the RR removed her from the facility where she subsequently expired. The MD reported he had not been made aware of any respiratory issues or low oxygen saturation levels and that a medical provider should have been notified because Resident #278 may have needed to be transferred to the hospital.<br><br>An interview was conducted on [DATE] at 2:35 pm with the Administrator. The Administrator reported she was not aware Resident #278 had a low oxygen saturation of the high 70's/low 80's and a medical provider had not been notified.<br><br>A review of the Emergency Department records dated [DATE] revealed Resident #278 presented to the hospital for evaluation of cough, congestion, and shortness of breath and had no respiratory history of Chronic Obstructive Pulmonary Disease (COPD, an inflammatory lung disease which causes difficulty breathing) or chronic respiratory illnesses. The RR stated Resident #278 had a cough and congestion for 2 weeks and they had asked for Resident #278 to be evaluated at the facility and felt like she had been neglected. Resident #278 reported weakness, cough, congestion, sore throat, and pleuritic pain (chest pain that gets worse with breathing). Resident #278 had an elevated white blood cell count (which indicated infection) of 14.4, a blood urea nitrogen (BUN) level of 24 (indicating mild dehydration), tested positive for Influenza A and received Decadron (a steroid used to reduce inflammation), intravenous fluid bolus (to improve dehydration), and a Duo-neb (a breathing treatment given through a nebulizer) treatment. Resident #278 was admitted to the hospital with a diagnosis of Influenza A and Influenzal Bronchitis.<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | A review of the Acute Hospital Death Summary dated [DATE] at 5:55 pm revealed Resident #278 had presented to the hospital on [DATE] with acute hypoxemic respiratory failure, tested positive for Influenza A and had a superimposed bacterial infection with Methicillin-resistant Staphylococcus aureus (MRSA, an infection resistant to many antibiotics) positivity. Resident #278 had right lower lobe consolidation (which indicates pneumonia), had received Vancomycin (antibiotic used to treat a wide variety of infections) and Rocephin (antibiotic used to treat respiratory tract infections). Resident #278 had increased oxygen requirements throughout her hospitalization and the infection continued to progress causing mucous plugging (mucous that builds up in the lungs and reduces the flow of air). Due to Resident #278's weak cough and debility, the RR placed Resident #278 on comfort measures and Resident #278 received inpatient hospice services in the hospital and died on [DATE] at 5:55 pm with the RR at bedside.<br><br>A review of a Certificate of Death dated [DATE] revealed Resident #278's immediate cause of death was acute hypoxemic respiratory failure, Influenza A, and bacterial pneumonia.<br><br>The Administrator was made aware of Immediate Jeopardy on [DATE] at 9:48 am.<br><br>The facility provided the following credible allegation of Immediate Jeopardy removal:<br><br>Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:<br><br>Resident #278 had a cough and on [DATE], Nurse #1 notified the provider of resident representative request for a chest x- ray. On [DATE], the provider assessed Resident #278 and did not order a chest x-ray. The facility didn't perform a chest x-ray requested by Resident #278's Representative when Resident #278 was observed to have a cough, congestion and decreased appetite by Nurse #1. The provider ordered Mucinex 600 milligrams every 12 hours for 7 days and Duo-neb treatments to be administered four times per day for 7 days for a cough. Resident #278 was observed having issues breathing on the morning on [DATE]. The Resident was assessed for change in condition by Medication Aide #1 with direction from the Director of Nurses. Resident was eventually discharged from the facility on [DATE] to an Acute Care Hospital by the resident representative. The facility failed to notify a provider when Resident #278 was noted by Medication Aide #1 to have difficulty breathing, had an oxygen saturation of the high 70's/low 80's, and was asking for help.<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | All residents are at risk of harm or due to the deficient practice. On [DATE], the Director of Nursing met with all direct care nurses who were working to initiate an assessment of 100% of current residents. This audit consisted of review of any residents with any acute change in condition to ensure the provider was notified of the change in condition. The change in condition included: Any symptom, sign or apparent discomfort that is: acute or sudden in onset, and is a marked change (i.e., more severe) in relation to usual symptoms and signs, or unrelieved by measures already prescribed including any change in condition where the resident has difficulty breathing, low oxygen saturations, and new onset cough, congestion with decreased appetite. This audit was completed on: [DATE]. The audit identified that 2 of 79 residents had an acute change in condition to include: Any symptom, sign or apparent discomfort that is: acute or sudden in onset, and is a marked change (i.e., more severe) in relation to usual symptoms and signs, or unrelieved by measures already prescribed including any change in condition where the resident has difficulty breathing, low oxygen saturations, new onset cough, and congestion with decreased appetite. On [DATE], corrective action was completed for 2 of 79 residents identified as having a change in condition when the provider was notified of the change in condition and orders for the change in condition were carried out by the direct care staff.<br><br>On [DATE], the Administrator audited all residents transferred to the hospital in the last 30 days ([DATE] - [DATE]) to ensure provider notification was completed for any acute change in condition to include: Any symptom, sign or apparent discomfort that is: acute or sudden in onset, and is a marked change (i.e., more severe) in relation to usual symptoms and signs, or unrelieved by measures already prescribed including any change in condition where the resident has difficulty breathing, low oxygen saturations, new onset cough, and congestion with decreased appetite. The audit identified that provider notification was completed for 22 of 22 residents. No current residents were identified as not having provider notification; therefore, no corrective action was required.<br><br>Specify the actions the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or reoccurring and when the action will be completed:<br><br>On [DATE] the Director of Nursing began in servicing all licensed nurses, Registered Nurses (RN) and Licensed Practical Nurses (LPN) and certified nursing assistants (full time, part time, and prn including agency) on the need to notify the provider for any acute change in condition to include: Any symptom, sign or apparent discomfort that is: acute or sudden in onset, and is a marked change (i.e., more severe) in relation to usual symptoms and signs, or unrelieved by measures already prescribed including any change in condition where the resident has difficulty breathing, low oxygen saturations, new onset cough, and congestion with decreased appetite.<br><br>The DON will ensure that all licensed nurses, RNs, LPNs, and CNAs (full time, part time, and prn including agency) who do not complete the in-service training by [DATE] will not be allowed to work until the training is completed.<br><br>This in-service was incorporated into the new employee facility and agency orientation for all licensed nurses and certified nursing assistants (full time, part time, and prn including agency) by the Director of Nursing.<br><br>Alleged date of IJ removal [DATE]<br><br>(continued on next page) |

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|---|---|---|---|
| | 345045 | A. Building<br>B. Wing | 07/03/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| The Foley Center at Chestnut Ridge | 621 Chestnut Ridge Parkway<br>Blowing Rock, NC 28605 |

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| F 0580<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | A validation of immediate jeopardy removal was conducted on [DATE]. The initial audit of residents was reviewed, and no issues were noted. Staff interviews across all departments were able to verbalize that they had received education on notification of change it condition, examples of change in condition, who to notify of a change in resident condition, etc. The staff were able to verbalize examples of a change in condition and the appropriate steps to take in notification, including the hall nurse, Director of Nursing, Administrator, and medical provider. The immediate jeopardy removal date of [DATE] was validated. |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50045<br><br>Based on record reviews, and Resident Representative (RR), staff, Nurse Practitioner (NP), and Medical Director (MD) interviews the facility failed to protect a Resident's right to be free from neglect when they failed to provide effective care and services to a resident experiencing a medical emergency. On [DATE] MA #1 was told by Nurse #2 that Resident #278 was not doing well. MA #1 checked Resident #278 and noted an oxygen saturation in the high 70's/low 80's (normal oxygen saturation is 92 to 100%), and got the Director of Nursing (DON). The DON advised MA #1 to place Resident #278 on oxygen and monitor oxygen saturation levels. MA #1 continued to report breathing issues and concern about Resident #278 to the DON throughout the day until Resident #278 was removed from the facility by the RR at 4:47 pm. The RR took Resident #278 to the Emergency Department where Resident #278 was diagnosed with Influenza A (the flu) Influenzal Bronchitis (inflammation of the airway), had an elevated white blood cell count (which indicated infection), and was given intravenous fluids, steroids (used to decrease inflammation), a breathing treatment, and was admitted to the hospital. Resident #278 was later diagnosed with acute hypoxemic respiratory failure and was placed on comfort measures on [DATE], received inpatient hospice services in the hospital and expired on [DATE]. The certificate of death revealed Resident #278's immediate cause of death was acute hypoxemic respiratory failure, Influenza A, and bacterial pneumonia. The deficient practice was identified for 1 of 4 residents (Resident #278) reviewed for neglect.<br><br>Immediate jeopardy began on [DATE] when Resident #278 experienced an acute change in condition and the facility neglected to provide effective care and services during a medical emergency. Immediate jeopardy was removed on [DATE] when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity of D (no actual harm with a potential for minimal harm that is not immediate jeopardy) to ensure education is completed and monitoring systems put into place are effective.<br><br>The findings included:<br><br>This tag is cross-referenced to:<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | F684: Based on record review, and staff, Resident Representative (RR), Social Worker (SW), Nurse Practitioner (NP), and Medical Director (MD) interviews Based on record review, and staff, Resident Representative (RR), Social Worker (SW), Nurse Practitioner (NP), and Medical Director (MD) interviews the facility failed to complete and document on-going thorough assessments for an acute change in condition and failed to respond effectively to a medical emergency. On [DATE] at 7:00 pm, Resident #278's Representative requested a chest x-ray, when Nurse #1 observed Resident #278 had a cough, congestion, and decreased appetite. Resident #278 was seen by the NP on [DATE] who ordered an oral medication for breaking up mucous/congestion every 12 hours and nebulizer breathing treatments four times a day were ordered for 7 days for a cough. On [DATE] at 7:00 am, Medication Aide (MA) #1 was told by the off going nurse, Nurse #2, that Resident #278 was not doing well. MA #1 checked Resident #278's oxygen saturation and noted it was in the high 70's/low 80's (normal oxygen saturation is 92 to 100%) and got the Director of Nursing (DON). The DON advised MA #1 to place Resident #278 on oxygen and continue to monitor oxygen saturation levels. MA #1 continued to report breathing issues and concern about Resident #278 struggling to breathe to the DON throughout the day until Resident #278 was removed from the facility by the RR at 4:47 pm. The RR took Resident #278 to the Emergency Department where Resident #278 was diagnosed with Influenza A (the flu) Influenzal Bronchitis (inflammation of the airway), had an elevated white blood cell count (which indicated infection), and was given intravenous fluids, steroids (used to decrease inflammation), a breathing treatment, and was admitted to the hospital. Resident #278 was later diagnosed with acute hypoxemic respiratory failure and was placed on comfort measures on [DATE], received inpatient hospice services in the hospital and expired on [DATE]. The certificate of death revealed Resident #278's immediate cause of death was acute hypoxemic respiratory failure, Influenza A, and bacterial pneumonia. The deficient practice was identified for 1 of 3 residents (Resident #278) reviewed for change in condition.<br><br>F580: Based on record review, staff, Social Worker (SW), Nurse Practitioner (NP), and Medical Director (MD) interviews the facility failed to notify a medical provider when Resident #278 was noted by Medication Aide (MA) #1 to have difficulty breathing, had an oxygen saturation in the high 70's/low 80's (normal oxygen saturation is 92 to 100%), and was asking for help. On [DATE] at 7:00 am MA #1 was told by Nurse #2 that Resident #278 was having issues with breathing. MA #1 checked Resident #278 and noted an oxygen saturation in the high 70's/low 80's, and got the Director of Nursing (DON). The DON advised MA #1 to place Resident #278 on oxygen and continue to monitor her oxygen saturation levels. MA #1 reported Resident #278's oxygen saturation levels remained in the 80's and she appeared to be struggling to breathe and was asking for help. MA #1 continued to report breathing issues and concern about Resident #278 throughout the shift to the DON until Resident #278 was removed from the facility on [DATE] at 4:47 pm by Resident #278's Representative (RR). The RR took Resident #278 to the Emergency Department where Resident #278 was diagnosed with Influenza A (the flu) Influenzal Bronchitis (inflammation of the airway), had an elevated white blood cell count (which indicated infection), and was given intravenous fluids, steroids (used to decrease inflammation), a breathing treatment, and was admitted to the hospital. Resident #278 was later diagnosed with acute hypoxemic respiratory failure and was placed on comfort measures on [DATE], received inpatient hospice services in the hospital and expired on [DATE]. The certificate of death revealed Resident #278's immediate cause of death was acute hypoxemic respiratory failure, Influenza A, and bacterial pneumonia. The deficient practice was identified for 1 of 3 residents reviewed for notification of change in condition (Resident #278).<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | An interview was conducted on [DATE] at 7:30 pm with Medication Aide (MA) #1. MA #1 stated she had received education on abuse and neglect from the facility. MA #1 stated an example of neglect would be not sending a resident to the hospital with a low oxygen saturation level that had not improved. MA #1 stated she felt as though Resident #278 had been neglected because the DON had not allowed her to send Resident #278 to the hospital.<br><br>An interview was conducted on [DATE] at 11:41 am with the Social Worker (SW). The SW stated staff used an online learning center to receive training. The SW reported staff continuously had training on neglect and abuse through their online learning center, in-services, monthly meetings, and on an as needed basis. The SW stated if a resident had a change in condition, such as a low oxygen saturation and difficulty breathing, and had not notified a medical provider, that could be considered neglect.<br><br>An interview was conducted on [DATE] at 12:39 pm with the Interim Director of Nursing (DON). The Interim DON stated facility staff received training on abuse and neglect yearly and as needed if an issue arose. The Interim DON stated neglect would be classified as not taking care of a resident and not acknowledging or reporting an issue with a resident. The Interim DON stated MA #1 not reporting a change in condition and not having a nurse come assess Resident #278 could be classified as neglect.<br><br>An interview was conducted on [DATE] at 11:56 am with the Administrator. The Administrator stated the facility utilized an online learning center for education and staff were educated on abuse and neglect during orientation. The Administrator stated neglect would be a resident who has not been bathed or changed. The Administrator stated she would not consider, not notifying a medical provider about a change in condition and not performing an assessment for a resident with a change in condition, to be neglect but instead a miscommunication.<br><br>The Administrator was made aware of Immediate Jeopardy on [DATE] at 10:49 am.<br><br>The facility provided the following credible allegation of Immediate Jeopardy removal:<br><br>Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On [DATE], Facility failed to follow abuse/neglect policy related to prohibiting neglect when Resident #278 had a change of condition and facility staff failed to notify Medical Director or Nurse Practitioner of change in condition and failed to notify Emergency Medical Services. Resident #278 had a cough and on [DATE], Nurse #1 notified the provider of resident representative request for a chest x- ray. On [DATE], the provider assessed Resident #278 and did not order a chest x-ray. The facility didn't perform a chest x-ray requested by Resident #278's Representative when Resident #278 was observed to have a cough, congestion and decreased appetite by Nurse #1. The provider did order Mucinex 600 milligrams every 12 hours for 7 days and Duo-neb treatments to be administered four times per day for 7 days for a cough. Resident #278 was observed having issues breathing on the morning on [DATE]. Resident was assessed for change in condition by Medication Aide #1 with direction from the Director of Nurses. Resident was eventually discharged from the facility on [DATE] to an Acute Care Hospital by the resident representative. The facility failed to notify a provider when Resident #278 was noted by Medication Aide #1 to have difficulty breathing, had an oxygen saturation of the high 70's/low 80's, and was asking for help. On [DATE], Upon being made aware of allegation of neglect, Administrator completed and submitted initial allegation report to Department of Health and Human Services. On [DATE], all current residents were assessed for change in condition to ensure anyone requiring change in condition received necessary care & services.<br><br>On [DATE], the Director of Nursing identified residents that were potentially impacted by this practice by completing head to toe body audits and assessed residents for any acute distress or verbal/nonverbal indicators of neglect with a BIMS 12 or less on all current residents. The results included: all current residents with BIMS 12 (impaired cognition) or less had no areas of concern identified related to abuse/neglect. On [DATE], all current residents with a BIMS of 13 or above were interviewed by the Administrator and were asked if they had any concerns related to abuse/neglect and if they had any care concerns. The results included: All current resident with BIMS 13 (intact cognition) or higher denied any allegations of abuse/neglect occurred and identified.<br><br>Additionally, on [DATE], the Director of Nursing met with all direct care nurses who were working to initiate an assessment of 100% of current residents. This audit consisted of review of any residents with any acute change in condition to ensure the provider was notified of the change in condition. The change in condition included: Any symptom, sign or apparent discomfort that is: acute or sudden in onset, and is a marked change (i.e., more severe) in relation to usual symptoms and signs, or unrelieved by measures already prescribed including any change in condition where the resident has difficulty breathing, low oxygen saturations, and new onset cough, congestion with decreased appetite. This audit was completed on: [DATE]. The audit identified that 2 of 79 residents had an acute change in condition to include: Any symptom, sign or apparent discomfort that is: acute or sudden in onset, and is a marked change (i.e., more severe) in relation to usual symptoms and signs, or unrelieved by measures already prescribed including any change in condition where the resident has difficulty breathing, low oxygen saturations, new onset cough, and congestion with decreased appetite. On [DATE], a corrective action was completed for 2 of 79 residents identified as having a change in condition when the provider was notified of the change in condition and orders for the change in condition were carried out by the direct care staff.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On [DATE], the Administrator audited all residents transferred to the hospital in the last 30 days ([DATE] - [DATE]) to ensure provider notification was completed for any acute change in condition to include: Any symptom, sign or apparent discomfort that is: acute or sudden in onset, and is a marked change (i.e., more severe) in relation to usual symptoms and signs, or unrelieved by measures already prescribed including any change in condition where the resident has difficulty breathing, low oxygen saturations, new onset cough, and congestion with decreased appetite. The audit identified that provider notification was completed for 22 of 22 residents. No current residents were identified as not having provider notification, therefore no corrective action was required.<br><br>Specify the actions the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or reoccurring and when the action will be completed:<br><br>On [DATE], Administrator and the Director of Nursing (DON) conducted in service for all full-time, part-time and as needed staff including agency on the abuse/neglect policy for reporting, identifying, and preventing abuse and neglect. All staff (full-time, part-time, and PRN staff, administration, housekeeping, dietary, nursing, therapy and maintenance) were in-serviced on identifying/reporting abuse/neglect immediately using our abuse policy and procedure. This education was completed in person and by phone. Any staff that was not educated by [DATE] will not be allowed to work until education is completed by Administration or department heads. Additionally, on [DATE] the Director of Nursing began in servicing all licensed nurses, Registered Nurses (RN) and Licensed Practical Nurses (LPN), Medication Aides and certified nursing assistants (full time, part time, and prn including agency) on the need to notify the provider for any acute change in condition to include: Any symptom, sign or apparent discomfort that is: acute or sudden in onset, and is a marked change (i.e., more severe) in relation to usual symptoms and signs, or unrelieved by measures already prescribed including any change in condition where the resident has difficulty breathing, low oxygen saturations, new onset cough, and congestion with decreased appetite. This education included: types of change in conditions, what to do when a change in condition is noted, who to notify, initiating Emergency Medical Services if needed and importance of providing care and services for any change in condition promptly and if care or services are not provided including not initiating call for Emergency Medical Services for assistance during a medical emergency is neglect.<br><br>The Interdisciplinary Team (Administrator, Director of Nursing, Nurse Managers, Minimum Data Set Coordinators, Unit Manager, Support nurse, Therapy, Health Information Management, Dietary Manager, Medical Director, Pharmacist), were notified of the allegation of neglect related to facilities failure in following and implementing policy related to abuse/neglect, identifying neglect and addressing change of condition in resident on [DATE] and were involved in the removal plan.<br><br>The Administrator and Director of Nurses will ensure that any staff member (full time, part time, and prn including agency) who do not complete the in-service training by [DATE] will not be allowed to work until the training is completed.<br><br>This in-service was incorporated into the new employee facility and agency orientation for all staff (full time, part time, and prn including agency) by the Director of Nurses.<br><br>Administrator will be responsible for ensuring the removal plan is implemented.<br><br>Alleged date of IJ removal [DATE]<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | A validation of immediate jeopardy removal was conducted on [DATE]. The initial audit of residents was reviewed, and no issues were noted. Staff interviews across all departments were able to verbalize that they had received education regarding abuse and neglect. The staff were able to verbalize examples of neglect, such as not assessing a resident with a change in condition, not notifying a provider of a change in condition, etc. The staff were able to verbalize what to do if they suspected a resident was being abused or neglected, which included letting the hall nurse know, and following the chain of command if no action was taken. The immediate jeopardy removal date of [DATE] was validated. |

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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement policies and procedures to prevent abuse, neglect, and theft.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38515<br><br>Based on record review and facility staff and Power of Attorney interviews, the facility failed to follow their abuse, neglect, and exploitation policies when they failed to immediately remove a nurse aide (Nurse Aide #10) from the facility following a reported allegation of potential abuse involving a resident (Resident #41). This resulted in the facility failing to protect the resident or other residents from potential further abuse. The facility also failed to thoroughly investigate an allegation of misappropriation of resident property involving Resident #26. This occurred for 2 of 4 residents reviewed for Abuse.<br><br>The findings included:<br><br>1. Review of the facility's policy titled Abuse Identification last revised in January 2023 read, in part, under the section, Taking Steps to Prevent Further Potential Abuse: The administrator or director of nursing should ensure that steps are taken to prevent further abuse from occurring. These actions may include but are not limited to: Suspending the employee.<br><br>Resident #41 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease with late onset, dementia with behaviors, and cognitive communication deficit.<br><br>Review of Resident #41's quarterly Minimum Data Set assessment dated [DATE] revealed Resident #41 was cognitively impaired with no delusions, behaviors, or rejection of care.<br><br>Review of facility provided allegations of abuse, neglect, or misappropriation revealed Resident #41 was involved in an altercation with Nurse Aide #10 on 01/27/24 in which Nurse Aide #11 heard shouting coming from Resident #41's room and when she arrived, she witnessed Nurse Aide #10 and Resident #41 standing close together and face to face with Nurse Aide #10's hand raised in the air toward Resident #41's face.<br><br>An interview with Nurse Aide #11 on 06/27/24 at 2:56 PM revealed she was working the evening of 01/27/24 and late in the evening, she heard shouting coming from Resident #41's room. Nurse Aide #11 reported she went to the room and when she walked into the room, she observed Nurse Aide #10 and Resident #41 standing face to face and Nurse Aide #10 had her right arm raised. She stated the way Nurse Aide #10's arm was raised she felt that Nurse Aide #10 was possibly going to put her hand over Resident #41's mouth or potentially strike her. Nurse Aide #11 reported she did not observe Nurse Aide #10 strike Resident #41 or cover her mouth but did ask Nurse Aide if she needed her to take over, to which Nurse Aide #10 replied no and then left the room. Nurse Aide #11 stated she stayed with Resident #41 who did not appear to be upset and then went and told her hall nurse, though she could not recall her name. Nurse Aide #11 stated she also could not recall if Nurse Aide #10 worked the rest of her shift or not. Nurse Aide #11 reported she had received training on abuse, neglect, and exploitation and indicated she felt she had followed the policies by reporting what she saw immediately to the nurse.<br><br>Review of facility provided schedules revealed Nurse #8 was assigned as the hall nurse the night of the incident. Additional review of the facility provided schedules revealed Nurse Aide #10 was scheduled to work 7:00 PM on 01/27/24 until 7:00 AM on 01/28/24.<br><br>(continued on next page) |

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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Multiple attempts to reach Nurse #8 by telephone were unsuccessful.<br><br>An interview with the Administrator on 06/28/24 at 1:28 PM revealed she was the facility's abuse coordinator and that she remembered the incident and stated it was her understanding that Nurse Aide #11 observed Nurse Aide #10 raise her hand in the face of Resident #41. When questioned about the reporting timeline, the Administrator reported it happened back in January, I'm not sure about the timeline and indicated she believed it was reported shortly after it was observed but stated it could have been the next morning. The Administrator reported she notified Nurse Aide #10, who was still working in the facility at the time, that an allegation of potential abuse had been made against her and that she was suspended pending the outcome of the facility's investigation. The Administrator verified that the facility policy on abuse, neglect, and exploitation included the immediate removal of any staff member who was accused of potential abuse pending the outcome of a full investigation. The Administrator did not have an answer to why Nurse Aide #10 was allowed to finish her shift and again reported she could not recall the timeline following the reported allegation. She indicated that Nurse Aide #10 should have been sent home immediately once Nurse Aide #11 reported the interaction to Nurse #8.<br><br>37280<br><br>2. Review of the facility's Abuse Identification policy revised 01/2023, read in part, the facility will develop and implement a system for investigating any incident or suspected incident of abuse defined as misappropriation of resident property (the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent). All reports of misappropriation of resident property shall be promptly and thoroughly investigated by facility management.<br><br>Resident #26 was admitted to the facility on [DATE].<br><br>Review of Resident #26's admission Minimum Data Set assessment dated [DATE] indicated he was cognitively intact.<br><br>A review of the facility's Initial Allegation Report, completed by the Administrator and sent to the State Agency on 05/20/24 at 4:39 PM revealed that Resident #26's friend went to the facility on [DATE] and reported fraudulent charges had been made on Resident #26's debit card on 05/02/24 to 2 vacation sites and 2 additional charges to a gambling site. The incident was reported to the local police department on 05/20/24 at 8:30 AM and Adult Protective Services (APS) on 05/20/24 at 10:11 AM.<br><br>A review of the facility's Investigation Report, completed by the Administrator on 05/20/24, revealed the incident resulted in mental anguish because Resident #26 was not able to pay one of his bills but whether the allegation was substantiated was not indicated in the Report. The report stated that all alert and oriented residents would be interviewed by facility leadership on 05/21/24. The facility Scheduler printed off copies of staff who worked the hall where Resident #26 resided from 05/17/24 through 05/20/24 and the Scheduler pulled records for 05/02/24. The Scheduler looked at cameras for 200 hall and did not see anything suspicious. The Investigation Report was submitted to the State Agency on 05/20/24 at 4:39 PM along with the Initial Report.<br><br>(continued on next page) |

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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review of a document titled Review to Ensure Quality dated 05/20/24 and completed by the Administrator revealed Resident #26 had cancelled his debit card and was calling his credit card companies to ensure there were no charges on any of his other cards. The document included that as immediate action residents would be asked not to bring anything valuable with them to the facility because there were a lot of people passing through all the time and they did not want anything to be misplaced or stolen. There have been several employees that have worked on the hall where Resident #26 resided since 05/17/24 and most of them have worked at the facility with no issues. There was one employee that the facility did not know well enough, and the Scheduler was looking at video footage of the past couple of days to see if that employee or anyone was hanging around the room where the Resident resided.<br><br>A review of an additional document titled Review to Ensure Quality dated 05/20/24 revealed a Root Cause Analysis (RCA) statement: On 05/20/24 Resident #26's POA notified the facility of fraudulent charges on his debit card made on 05/02/24. The Resident's wallet with his debit and credit cards were left in his room in his night stand since his admission to the facility on [DATE] unsecure while he was at the hospital due to emergent issues. The Residents were advised not to bring anything of value with them during their stay at the facility because there were several people always coming in and out of the building. Some were facility staff which were known to be trustworthy, but some were agency and guests of other residents. On 05/20/24 all residents who were cognitively intact will be interviewed and asked if they had any concerns with misappropriation of property. For the residents with moderately and severely impaired cognition, the grievances and concerns for the last 30 days were reviewed for issues of misappropriation of resident property and there were no concerns identified. On 05/20/24 the interim Director of Nursing began inservicing all full time, part time and as needed staff including agency staff on Abuse (Misappropriation of Resident Property). The document was signed by the Administrator on 05/22/24.<br><br>On 06/26/24 at 11:38 AM and 07/02/24 at 12:42 PM interviews were conducted with the Social Worker who reported that on the early morning of 05/20/24 Resident #26's Power of Attorney (POA) brought to her attention a banking statement with fraudulent charges made with the Resident's debit card of approximately 2,000 dollars. The POA stated he believed someone had taken Resident #26's debit card numbers while the Resident kept his debit and credit cards in his wallet in the night stand in his room. The SW stated her initial thought was that someone had taken a picture of Resident #26's debit card while it was in his nightstand because the debit card was accounted for. The SW stated she interviewed residents who were cognitively intact on the hall that Resident #26 resided on about misappropriation of resident property and there were no concerns reported but she did not interview resident families or representatives of residents who had lesser cognition. She stated she did not think about doing that but in retrospect she should have. The SW reported she was unable to interview Resident #26 about the incident after he returned from the hospital because of his altered mental status.<br><br>Interviews were conducted with Resident #26's Power of Attorney on 06/26/24 at 10:30 AM and 06/27/24 at 10:01 AM. The POA explained that after he reported the issue to the facility on [DATE] he went to the bank to report the fraudulent charges on Resident #26's debit card and after some research the bank informed him that they identified some unusual activity on the Resident's bank account and that multiple attempts had been made with his on line banking and whoever made the attempts, had his account information and the routing numbers on his checks which was not kept in his night stand. The bank informed him that the charges could have happened from anywhere because whoever made the charges had to have access to his routing numbers and banking information.<br><br>(continued on next page) |

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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 06/28/24 at 12:47 PM and 07/02/24 at 12:55 PM during interviews conducted with the interim Director of Nursing (DON), the DON explained that on 05/21/24 she was asked to interview and educate staff regarding misappropriation of resident property but did not interview about specifics pertaining to Resident #26 debit card charges because she did not know the specifics. She stated she had never investigated anything before, so she picked random staff to interview and educate on misappropriation of resident property but did not keep documentation of her actions.<br><br>An interview was conducted with the Administrator on 06/26/24 at 12:01 PM. The Administrator explained that on 05/20/24 the Social Worker informed her that Resident #26's POA reported some fraudulent charges had been made on the Resident's debit card account and the Administrator reported the allegation to APS and the State Agency. The SW informed the local police department who investigated the allegation. The Administrator continued to explain that Resident #26 was in the hospital at the time the allegation was made on 05/20/24 but that the Social Worker interviewed the Resident when he returned to the facility after 05/21/24. Administrator indicated facility staff from all departments were interviewed by the interim Director of Nursing if they noticed anything out of the ordinary or anyone different going in and out of Resident #26's room and no reports came from those interviews. She stated herself and the Scheduler looked at video footage at areas around the Resident's room and did not see anything abnormal. She indicated they did not interview staff who had worked with Resident #26 in the days leading up to the alleged date of the fraudulent charges (05/02/24). She indicated she did not interview all the staff because she followed the guidance from the corporate staff and did not think all staff should be interviewed. The Administrator reported the SW interviewed alert and oriented residents and they reviewed grievances and concerns filed on behalf of residents with cognitive impairment to see if anyone had reported any issues with misappropriation of resident property and there were no identified concerns from those reviews. The Administrator educated the facility management team and informed them that there were a lot of people in the building and to be careful about bringing items of value into the facility and the management team divided up the residents by halls and educated the residents about bringing valuables into the facility. The Administrator stated she did not indicate on the investigation report if the allegation was substantiated or unsubstantiated because she was unsure if she was supposed to although she felt it should be unsubstantiated because there were no witnesses to anything that proved Resident #26's banking account routing numbers were taken from the facility or how the account was compromised.<br><br>During a follow up interview with the Administrator on 07/02/24 at 3:00 PM she was informed the SW revealed during interview that she had not interviewed Resident #26 when he returned from the hospital. The Administrator revealed she was not aware of this information. |

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| F 0644<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38515<br><br>Based on record review and facility staff interviews, the facility failed to request a Pre-admission Screening and Resident Review (PASARR) review for a resident who was newly diagnosed with psychosis for 1 of 1 resident reviewed for level II PASARR. (Resident #50)<br><br>The findings included:<br><br>Resident #50 was admitted to the facility on [DATE] with diagnoses that included depression, and anxiety disorder.<br><br>Review of Resident #50's quarterly Minimum Data Set assessment dated [DATE] revealed her to be moderately impaired with no delusions, behaviors, rejection of care, or instances of wandering. Resident #50 was coded as receiving antipsychotic and antidepressant medication. Resident #50 was coded as receiving antipsychotic medications on a routine basis and that a gradual dose reduction had been attempted and was not clinically contraindicated.<br><br>Review of Resident #50's medical record revealed a pharmacy review dated 11/10/23 that requested a clarification diagnosis for the use of an antipsychotic. Additionally, the pharmacy review request was addressed by the facility's Nurse Practitioner on 11/01/23 who diagnosed Resident #50 with psychosis and was signed by the facility's Nurse Practitioner. The pharmacy review also had handwritten notes at the bottom that read: New diagnosis: psychosis via verbal order by [Nurse Practitioner] initialed off by the<br><br>Director of Nursing.<br><br>An interview with the Social Worker on 06/27/24 at 4:53 PM revealed she was the staff member responsible for requesting PASARR reviews at the facility. The Social Worker explained she would request a PASARR review if a resident at the facility had a change in mental health needs or received a new diagnosis of a serious mental health condition. She reported the facility's mental health provider typically handled diagnosing residents with mental health conditions and would inform her if there was a change in a resident's condition or a new diagnosis of a mental health condition. The SW continued, stating she had not requested a PASARR review for Resident #50 because she was never informed that Resident #50 had been given a new mental health diagnosis of psychosis. She reported she would have expected to have been notified that Resident #50 had been diagnosed with a new mental health condition.<br><br>An interview with the facility's Nurse Practitioner on 06/28/24 at 11:35 AM revealed she did not know the process for informing other staff of new diagnoses. She stated she felt it was not unusual for her to give residents new diagnoses and stated she did not know what the process was for relaying that information to the Social Worker if it would require a PASARR review. She reported she had diagnosed Resident #50 due to her knowledge of some reported auditory and visual hallucinations and that she felt it was an appropriate diagnosis at the time.<br><br>(continued on next page) |

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| F 0644<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | An interview with the Director of Nursing was unable to be completed as she was out of the facility and unable to be reached.<br><br>An interview with the Acting Director of Nursing on 06/28/24 at 11:56 AM revealed the facility's process was once a resident was given a new diagnosis, a form was completed and sent to medical records. Medical records would then review the diagnosis and enter the diagnosis in the medical record and upload the form into the medical documents. She stated with Resident #50 it appeared as though the Director of Nursing uploaded the form herself and that she must not have reported the new diagnosis to medical records so they could enter it into the health record of Resident #50. She indicated if the diagnosis had been reported to medical records, then the Social Worker would have been notified and she would have initiated a PASARR review request. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37280<br><br>Based on observations, record reviews and interviews the facility failed to implement a care plan intervention of placing a rubbery flexible sheet used to prevent sliding to a wheelchair for 1 of 4 residents (Resident #28) reviewed for accidents.<br><br>The finding included:<br><br>Resident #28 was admitted to the facility on [DATE] with diagnoses that included cerebral vascular accident (CVA) and dementia.<br><br>The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #28's cognition was moderately impaired and required moderate assistance with transfers. The MDS indicated the Resident had 2 falls since the last MDS assessment.<br><br>A review of a progress note dated 04/11/24 read in part, Resident was transferring self from wheelchair to bed and did not lock the brakes causing him slide to the floor and land on his bottom.<br><br>A review of Resident #28's care plan revised 04/11/24 revealed the Resident had an actual fall with risks of further falls related to poor balance. The goal that Resident #28 would resume usual activities without further incident would be attained by adding a rubbery flexible sheet to prevent sliding in his wheelchair.<br><br>A review of Resident #28's medical record revealed an order dated 04/12/24 for a rubbery flexible sheet to prevent sliding to be placed between the Resident's wheelchair and wheelchair cushion and not to be placed between the wheelchair and resident. The order was written by Nurse Supervisor #1.<br><br>A review of Resident #28's Kardex (a guide for nurse aides to deliver care) dated 06/27/24 included a rubbery flexible sheet to prevent sliding in wheelchair.<br><br>On 06/27/24 at 4:01 PM an observation of Nurse Aide (NA) #1 and NA #2 was made of transferring Resident #28 from his wheelchair to the commode. There was no rubbery sheet in the Resident's wheelchair which was acknowledged by the NAs.<br><br>Interviews were conducted at 4:04 PM on 06/27/24 with NA #1 and NA #2 simultaneously. The NA's explained that they mostly worked on the hall that Resident #28 resided on, and reported the Resident had a history of falls. The NAs stated they did not know that he was supposed to have the rubbery sheet in his wheelchair. Both NAs acknowledged the intervention was on his Kardex.<br><br>An interview was conducted with Nurse Supervisor #1 on 06/28/24 at 9:01 PM who explained that falls were reviewed every morning after the management meeting and interventions were discussed and relayed to the care plan. The Supervisor remembered discussing Resident #28's fall and writing the order for the rubbery sheet to be put in his wheelchair. The Supervisor stated if the intervention was put on the care plan, then she expected the intervention to be done.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The interim Director of Nursing (DON) was interviewed on 06/28/24 at 12:50 PM. The DON explained that falls were discussed in the morning meeting where interventions were decided and put on the care plan. The interim DON stated if the care plan called for the rubbery sheet to be in the Resident's wheelchair, then it should be in his wheelchair. |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50045<br><br>Based on record review, and staff, Resident Representative (RR), Social Worker (SW), Nurse Practitioner (NP), and Medical Director (MD) interviews Based on record review, and staff, Resident Representative (RR), Social Worker (SW), Nurse Practitioner (NP), and Medical Director (MD) interviews the facility failed to complete and document on-going thorough assessments for an acute change in condition and failed to respond effectively to a medical emergency. On [DATE] at 7:00 pm, Resident #278's Representative requested a chest x-ray, when Nurse #1 observed Resident #278 had a cough, congestion, and decreased appetite. Resident #278 was seen by the NP on [DATE] who ordered an oral medication for breaking up mucous/congestion every 12 hours and nebulizer breathing treatments four times a day were ordered for 7 days for a cough. On [DATE] at 7:00 am, Medication Aide (MA) #1 was told by the off going nurse, Nurse #2, that Resident #278 was not doing well. MA #1 checked Resident #278's oxygen saturation and noted it was in the high 70's/low 80's (normal oxygen saturation is 92 to 100%) and got the Director of Nursing (DON). The DON advised MA #1 to place Resident #278 on oxygen and continue to monitor oxygen saturation levels. MA #1 continued to report breathing issues and concern about Resident #278 struggling to breathe to the DON throughout the day until Resident #278 was removed from the facility by the RR at 4:47 pm. The RR took Resident #278 to the Emergency Department where Resident #278 was diagnosed with Influenza A (the flu) Influenzal Bronchitis (inflammation of the airway), had an elevated white blood cell count (which indicated infection), and was given intravenous fluids, steroids (used to decrease inflammation), a breathing treatment, and was admitted to the hospital. Resident #278 was later diagnosed with acute hypoxemic respiratory failure and was placed on comfort measures on [DATE], received inpatient hospice services in the hospital and expired on [DATE]. The certificate of death revealed Resident #278's immediate cause of death was acute hypoxemic respiratory failure, Influenza A, and bacterial pneumonia. The deficient practice was identified for 1 of 3 residents (Resident #278) reviewed for change in condition.<br><br>Immediate jeopardy began on [DATE] when the facility failed to complete thorough assessments after Resident #278's acute change in condition and respond effectively to a medical emergency. Immediate jeopardy was removed on [DATE] when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity of D (no actual harm with a potential for minimal harm that is not immediate jeopardy) to ensure education is completed and monitoring systems put into place are effective.<br><br>The findings included:<br><br>Resident #278 was readmitted to the facility on [DATE] with a diagnosis of heart disease. Resident #278 did not have a diagnosis of chronic obstructive pulmonary disease (COPD, inflammation of the lungs which causes decreased airflow).<br><br>A review of a Medical Orders for Scope of Treatment (MOST) form dated [DATE] revealed Resident #278 was a full code and wished to receive all medical interventions including intubation, advanced airway interventions, mechanical ventilation, cardioversion (a procedure using electricity and medications to convert the heart from an irregular rhythm to a normal rhythm) as indicated, medical treatment, intravenous fluids, and to be transferred to the hospital if indicated.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | A review of the Facility Standing Orders, last reviewed on [DATE] by the Medical Director (MD), revealed if a resident experienced shortness of breath, oxygen could be administered at 2 liters/minute and the MD should be notified of a change in condition.<br><br>A review of a care plan dated [DATE] revealed Resident #278 had an advanced directive in place and her wishes were to be honored.<br><br>An admission Minimum Data Set assessment (MDS) dated [DATE] revealed Resident #278 was cognitively intact with no behaviors, required supervision for bed mobility, transfers, and toileting. Resident #278 was not documented as using oxygen.<br><br>A review of a nursing progress note dated [DATE] at 7:29 pm written by Nurse #3 revealed Resident #278 was medicated for a dry cough and had two negative coronavirus (COVID) tests.<br><br>An interview was conducted on [DATE] at 5:20 pm with Nurse #3. Nurse #3 stated she worked day shift (7:00 am to 7:00 pm) on [DATE] and was assigned Resident #278. She reported at that time, Resident #278 had a dry cough, and she performed a COVID test, which had a negative result. Nurse #3 stated she was not able to recall Resident #278 being short of breath at that time.<br><br>A review of a provider communication form dated [DATE] at 7:00 pm completed by Nurse #1 revealed Resident #278 presented with a cough, congestion and decreased appetite. Nurse #1 documented Resident #278's RR requested a chest x-ray and for the resident to be seen on [DATE].<br><br>A review of the Electronic Health Record (EHR) revealed no documented head to toe assessment on [DATE] by Nurse #1.<br><br>A review of the provider notification form dated [DATE] at 7:00 pm revealed Resident #278's vital signs included a blood pressure of ,d+[DATE], heart rate of 70 beats/minute, a temperature of 97.3 degrees Fahrenheit, respiration rate of 17 breaths/minute, and oxygen saturation level of 95% on room air. Documentation was completed by Nurse #1.<br><br>A review of the Electronic Health Record revealed an assessment dated [DATE] at 3:15 pm which indicated Resident #278 was alert and oriented (to person, time, place, and situation), lung sounds were clear, and a dry cough was noted. Vital signs were documented and revealed a blood pressure of ,d+[DATE], heart rate of 63 beats/minute, temperature of 98.2 degrees Fahrenheit, respiration rate of 20 breaths/minute, and oxygen saturation of 93% on room air. Documentation was completed by Nurse Supervisor #2.<br><br>An interview was conducted on [DATE] at 6:04 pm with Nurse #1. Nurse #1 reported she worked on [DATE] during dayshift (7:00 am to 7:00 pm) and was assigned Resident #278. Nurse #1 reported the RR approached her and stated she was worried about Resident #278 because she had been sick a few days, had a cough, and congestion. Nurse #1 reported that she assessed Resident #278 and obtained vital signs. Nurse #1 reported Resident #278 had a lot of congestion but was not having difficulty breathing and was afebrile (not running a fever). Nurse #1 stated she completed the provider communication sheet and placed the completed sheet in the provider communication book at the nurse's station. Nurse #1 stated she had not called the on-call provider on [DATE], because Resident #278's vital signs were stable, and she had not heard any rales or crackles (lung sounds).<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | A review of Resident #278's progress notes revealed no documentation was written on [DATE] by the Nurse Practitioner (NP).<br><br>An interview was conducted on [DATE] at 11:12 am with the NP. The NP reported she had seen Resident #278 on [DATE] per RR request. The NP stated during the visit she had not recalled Resident #278 having any shortness of breath or respiratory distress. The NP stated she noted Resident #278 had a cough and congestion and had not felt like a chest x-ray was warranted at that time. The NP stated she ordered Guaifenesin and Duo-neb treatments to treat the cough and congestion. The NP stated she never received any additional notification that Resident #278 had continued to have respiratory issues. The NP stated she had forgotten to finish and sign the note for Resident #278's encounter.<br><br>A review of Resident #278's physician orders dated [DATE] at 12:00 pm revealed Resident #278 was prescribed Guaifenesin Extended Release (ER) 600 mg tablet every 12 hours for expectorant for seven days and Duo-neb Solution (nebulizer breathing treatments) to be inhaled orally via nebulizer four times per day for seven days for a cough and was written by the NP.<br><br>A review of the Medication Administration Record (MAR) from [DATE] revealed Resident #278 was documented as receiving Guaifenesin ER 600 mg every 12 hours and Duo-nebs four times a day for seven days as ordered.<br><br>A review of the Electronic Health Record revealed an assessment dated [DATE] at 3:15 pm which indicated Resident #278 was alert and oriented (to person, time, place, and situation), lung sounds were clear, and a dry cough was noted. Vital signs were documented and revealed a blood pressure of ,d+[DATE], heart rate of 63 beats/minute, temperature of 98.2 degrees Fahrenheit, respiration rate of 20 breaths/minute, and oxygen saturation of 93% on room air. Documentation was completed by Nurse Supervisor #2.<br><br>An interview was conducted on [DATE] at 5:25 pm with Nurse Aide (NA) #6. NA #6 verified she had been assigned to care for Resident #278 on [DATE] and [DATE] during dayshift (7:00 am to 7:00 pm). NA #6 reported she was unable to recall Resident #278 being sick at that time.<br><br>NA #7 was assigned to care for Resident #278 on [DATE] during night shift (7:00 pm to 7:00 am). NA #7 was unavailable for an interview.<br><br>Nurse #12 was assigned to care for Resident #278 on [DATE] during night shift (7:00 pm to 7:00 am). There were no nursing progress notes entered by Nurse #12 on [DATE] from 7:00 pm to 7:00 am.<br><br>An attempt was made to contact Nurse #12 on [DATE] and was unsuccessful.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | A telephone interview was conducted on [DATE] at 7:30 pm with MA #1. MA #1 reported she worked on [DATE] during dayshift (7:00 am to 7:00 pm) and was assigned Resident #278. MA #1 stated she had just returned to work after being out with Influenza at the end of [DATE]. MA #1 stated she received a report from Nurse #2 at 7:00 am and was told by Nurse #2 that Resident #278 was not doing well. MA #1 reported she immediately checked on Resident #278 at 7:00 am and noticed Resident #278 was struggling with breathing and asking for help. MA #1 reported she obtained an oxygen saturation level in the low 70's/high 80's but was unable to recall the exact result. MA #1 stated she immediately got the Director of Nursing (DON) and was instructed to place Resident #278 on oxygen and to continue checking oxygen saturation levels. MA #1 stated the DON went in the room; however, MA #1 was not able to recall the DON performing an assessment. MA #1 reported she placed Resident #278 on 2 to 4 liters/minute, was unable to recall exact amount of oxygen, and routinely checked Resident #278's oxygen level throughout the shift. MA #1 reported she had not recalled Resident #278's oxygen level rising above 90% at all that day. MA #1 was unable to recall Nurse #11 and was not able to recall asking Nurse #11 for help with Resident #278. MA #1 stated she told the DON multiple times during her shift about Resident #278 struggling to breathe, low oxygen saturation levels, and how she felt Resident #278 needed to be sent to the hospital but no one would listen to her. MA #1 verified she had only reported her concerns for Resident #278 to the DON, and assumed that she would have notified the MD. MA #1 received no response from the DON. MA #1 stated she continued to check Resident #278's oxygen saturation often but was unable to recall getting a full set of vital signs. MA #1 reported she did not check Resident #278's oxygen saturation after the RR arrived and prior to Resident #278 leaving the facility with the RR. MA #1 reported she was passing medications to other residents on the hall at the time Resident #278 was removed from the facility by the RR.<br><br>Review of the medical record revealed there were no vital signs documented for Resident #278 on [DATE].<br><br>Nurse #11 was assigned to care for Resident #278 on [DATE] during day shift (7:00 pm to 7:00 am). There were no nursing progress notes entered by Nurse #11 on [DATE].<br><br>An interview was conducted on [DATE] at 3:05 pm with Nurse #11. Nurse #11 reported she worked as an agency nurse at the facility on [DATE] on dayshift and was assigned Resident #278. Nurse #11 reported she was unable to remember Resident #278 or any events that occurred on [DATE].<br><br>The DON was unavailable for an interview.<br><br>An interview was conducted on [DATE] at 3:07 pm with Nurse Aide (NA) #1. NA #1 stated she worked on [DATE] from 7:00 am to 7:00 pm and was assigned Resident #278. NA #1 stated she was able to remember Resident #278's RR came and got her that day. NA #1 stated Resident #278 had complained about hurting in her chest, could hardly talk because she was short of breath and was more tired than usual. NA #1 stated Resident #278 remained in bed on [DATE] and was unable to recall if Resident #278 wore oxygen. NA #1 could not remember if she had taken any vital signs or if Resident #278 had ate/drank anything on [DATE].<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | A review of a progress note dated [DATE] at 1:44 pm written by Nurse Supervisor #1 revealed she was contacted by Medication Aide (MA) #1 due to Resident #278 having a high blood pressure ,d+[DATE] per automatic cuff and ,d+[DATE] when taken manually. Resident #278 was out of her blood pressure medication because the RR had not delivered it to the facility. Nurse Supervisor #1 contacted the NP and was advised to wait for the arrival of the blood pressure medications. Nurse Supervisor #1 stated she had called the RR regarding the blood pressure medication and reported the RR was upset and accused the facility of not medicating Resident #278, at which time the RR was asked to speak to the Administrator.<br><br>An interview was conducted on [DATE] at 3:57 pm with Nurse Supervisor #1. Nurse Supervisor #1 stated she worked on [DATE]. Nurse Supervisor #1 stated Resident #278's RR was responsible for bringing medications to the facility, because she had not wanted to use the facility's pharmacy. Nurse Supervisor #1 recalled MA #1 had contacted her on [DATE] about Resident #278's high blood pressure and not having blood pressure medication available at that time. Nurse Supervisor #1 stated she contacted the NP and was advised to wait on the RR to bring the medication. Nurse Supervisor #1 reported she had not gone to assess Resident #278 because she was never informed by MA #1 that Resident #278 was having difficulty breathing.<br><br>A review of a progress note dated [DATE] at 2:08 pm written by Nurse Supervisor #1 revealed Resident #278's RR had still not brought medication to the facility and the RR alleged the facility had deliberately not administered Resident 278's medications for three days. The Nurse Supervisor had called to inform the RR, the RR became upset and accused the facility of not medicating Resident #278, and the RR was then transferred via phone to the Administrator.<br><br>A review of a progress note dated [DATE] at 4:47 pm written by the Social Worker (SW) revealed Resident #278's RR came to the facility on [DATE] and removed Resident #278 from the facility. The SW documented the RR was upset regarding medications and felt they could no longer leave Resident #278 in the facility. The SW assisted the RR in the room with packing her belongings and provided them with copies of her paperwork and medication list. The RR was given the leftover bottles of medications because the RR had provided those. The SW asked the RR to take an oxygen tank with them due to her oxygen levels had been falling at times, but they refused and stated they were going straight to the emergency room from the facility and declined the offer. The RR refused to wait for proper discharge on [DATE] at 4:47 pm.<br><br>An interview was conducted on [DATE] at 2:10 pm with the SW. The SW reported that when the RR arrived, she went to the room with her to pack up Resident #278's belongings. The RR stated Resident #278 was really sick and they were going to take her straight to the Emergency Department. The SW stated Resident #278 had been having respiratory issues for a few days and had received treatment for respiratory symptoms. The SW stated she observed Resident #278 to be sleepy and appeared out of it prior to the RR's arrival at the facility. The SW stated she accompanied the RR to Resident #278's room, Resident #278 was easily aroused but appeared very sick. The SW recalled MA #1 was in the process of calling the on-call provider when the RR arrived due to concern over Resident #278's breathing and was concerned that the respiratory issues had progressed to pneumonia. The SW stated she informed the RR that MA #1 was calling the MD, but the RR insisted on removing Resident #278 from the facility anyway. The SW stated the RR refused to wait on proper discharge paperwork and refused to take an emergency oxygen tank with them. The SW stated she assisted Resident #278 to the RR's vehicle via wheelchair and buckled her in the car on [DATE] at 4:47 pm.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | A follow-up interview was conducted on [DATE] at 11:41 am with the SW. The SW reported she had walked down 400-hall and remembered MA #1 stating Resident #278 was not doing very good and did not look good around 11:30 am. The SW stated she asked MA #1 if she had notified anyone. The SW stated MA #1 had told her Resident #278's oxygen saturation levels were dropping, and that MA #1 had placed Resident #278 on oxygen and that Resident #278 had maintained oxygen levels between ,d+[DATE]% afterwards. The SW stated she went in the room and observed Resident #278 on oxygen and stated she looked sick. The SW stated after she left the room, she immediately went to talk to the DON but was met near the front entrance of the facility by the RR. The SW reported she had not been able to speak with the DON prior to Resident #278 was removed from the facility on [DATE] at 4:47 pm by the RR. The SW verified the DON had not gotten to assess Resident #278 when the RR arrived. The SW was unable to explain the lapse in time between when she noticed Resident #278 looked sick and when she was going to speak with the DON at 4:47 pm.<br><br>An interview was conducted on [DATE] at 4:27 pm with the Resident #278's Representative (RR). The RR stated they would not go into details about the event when Resident #278 was removed from the facility but stated Resident #278 had been taken to the hospital, diagnosed with the flu, and later died , and stated it all could have been prevented. The RR refused to answer any additional questions.<br><br>A review of the Emergency Department (ED) records dated [DATE] revealed Resident #278 presented to the hospital for evaluation of cough, congestion, and shortness of breath and had no respiratory history of chronic obstructive pulmonary disease or chronic respiratory illnesses. Vital signs on arrival to the ED were blood pressure of ,d+[DATE], heart rate of 77 beats per minute, 18 breaths per minute, temperature of 98 degrees Fahrenheit, and an oxygen saturation of 92%. The ED record did not specify if Resident #278 was on oxygen or room air in the ED. The RR stated Resident #278 had a cough and congestion for 2 weeks and they had asked for Resident #278 to be evaluated at the facility and felt like she had been neglected. Resident #278 reported weakness, cough, congestion, sore throat, and pleuritic pain (chest pain that gets worse with breathing). Resident #278 had an elevated white blood cell count (which indicated infection) of 14. 4, a blood urea nitrogen (BUN) level of 24 (indicating mild dehydration), tested positive for Influenza A and received Decadron (a steroid used to reduce inflammation), intravenous fluid bolus (to improve dehydration), and a Duo-neb treatment. Resident #278 was admitted to the hospital with a diagnosis of Influenza A and Influenzal Bronchitis.<br><br>A hospital progress note dated [DATE] at 9:32 pm revealed Resident #278 was wheezing, had rhonchi (gurgling or bubbling sounds), and had an oxygen saturation in the upper 80's. Resident #278 was placed on 2 liters of oxygen per min via nasal canula.<br><br>A hospital nursing note dated [DATE] at 7:47 pm revealed Resident #278 struggled to maintain an oxygen saturation greater than 91% and supplemental oxygen had to be increased to 4 liters of oxygen per minute via nasal canula. Resident #278 complained of a sore throat, bright red blood in sputum, and had a chest x-ray that showed pneumonia. Resident #278 was placed on Vancomycin (antibiotic used to treat a broad spectrum of infections) and Rocephin (antibiotic).<br><br>A hospital communication and patient planning note dated [DATE] revealed Resident #278 was on 6 liters of oxygen per minute via nasal canula.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | A review of the Acute Hospital Death Summary dated [DATE] at 5:55 pm revealed Resident #278 had presented to the hospital on [DATE] with acute hypoxemic respiratory failure, tested positive for Influenza A and had a superimposed bacterial infection with Methicillin-resistant Staphylococcus aureus (MRSA, an infection resistant to many antibiotics) positivity. Resident #278 had right lower lobe consolidation (which indicates pneumonia), had received Vancomycin (antibiotic used to treat a wide variety of infections) and Rocephin (antibiotic used to treat respiratory tract infections). Resident #278 had increased oxygen requirements throughout her hospitalization and the infection continued to progress causing mucous plugging (mucous that builds up in the lungs and reduces the flow of air). Due to Resident #278's weak cough and debility, the RR placed Resident #278 on comfort measures and Resident #278 received inpatient hospice services in the hospital and died on [DATE] at 5:55 pm with the RR at bedside.<br><br>A review of a Certificate of Death dated [DATE] revealed Resident #278's immediate cause of death was acute hypoxemic respiratory failure, Influenza A, and bacterial pneumonia.<br><br>An interview was conducted on [DATE] at 6:19 pm with the Infection Preventionist (IP). The IP stated there had been no Influenza or COVID outbreaks so far in 2024. The IP was unable to find any Influenza testing results for Resident #278.<br><br>An interview was conducted on [DATE] at 4:40 pm with Nurse Supervisor #2. Nurse Supervisor #2 reported she had worked with Resident #278 a few times and remembered that she had been lying in bed more often and she had a cough. She stated Resident #278 was tested for Influenza and COVID at the facility around [DATE], however she was not able to locate the order for Influenza testing or test results. Nurse Supervisor #2 stated if Resident #278 had been having upper respiratory infection symptoms, nursing assessments should have been completed at least weekly or with breathing treatments. Nurse Supervisor #2 stated the last documented nursing assessment, according to the Electronic Health Record (EHR), was in December of 2023. Nurse Supervisor #2 reported she was not sure why an assessment had not been documented since then, and reported an assessment should have been performed if there was a change in condition or if the resident had experienced respiratory infection symptoms.<br><br>An interview was conducted on [DATE] at 11:12 am with the NP. The NP stated she never received any notification on [DATE] that Resident #278 had any respiratory issues or had required the use of oxygen for low oxygen saturation levels and reported the assigned staff member should have notified a medical provider.<br><br>A telephone interview was conducted on [DATE] at 4:16 pm with the MD. The MD stated he had cared for Resident #278 at the facility and reported she had been slowly dwindling and spending more time in bed since admission. The MD reported Resident #278 had no significant medical illnesses. The MD stated he was not aware that Resident #278 had been taken to the Emergency Department on [DATE] after the RR removed her from the facility where she subsequently expired. The MD reported he had not been made aware of any respiratory issues or low oxygen saturation levels and that a medical provider should have been notified because Resident #278 may have needed to be transferred to the hospital.<br><br>An interview was conducted on [DATE] at 2:35 pm with the Administrator. The Administrator reported she had spoken to the RR on [DATE] about concerns regarding medications. The Administrator reported Resident #278 had not been sick but that the RR had come and removed her because of issues with medications and the RR accusing the facility of not medicating Resident #278. The Administrator reported she was not aware Resident #278 had been transferred to the hospital on [DATE] and later expired.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | The Administrator was made aware of Immediate Jeopardy on [DATE] at 9:48 am.<br><br>The facility provided the following credible allegation of Immediate Jeopardy removal:<br><br>Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:<br><br>Resident #278 had a cough and on [DATE], Nurse #1 notified the provider of resident representative request for a chest x- ray. On [DATE], the provider assessed Resident #278 and did not order a chest x-ray. The facility didn't perform a chest x-ray requested by Resident #278's Representative when Resident #278 was observed to have a cough, congestion and decreased appetite by Nurse #1. The provider ordered Mucinex 600 milligrams every 12 hours for 7 days and Duo-neb treatments to be administered four times per day for 7 days for a cough. Resident #278 was observed having issues breathing on the morning on [DATE]. Resident was assessed for change in condition by Medication Aide #1 with direction from the Director of Nurses. Resident was eventually discharged from the facility on [DATE] to an Acute Care Hospital by the resident representative. The facility failed to provide effective assessments and interventions for a change in condition. The facility failed to effectively respond to a medical emergency.<br><br>All residents are at risk of serious harm or death due to the deficient practice. On [DATE], the Director of Nursing met with all direct care nurses who were working to initiate an assessment of 100% of current residents. This audit consisted of review of any residents with any acute change in condition to include: Any symptom, sign or apparent discomfort that is: acute or sudden in onset, and is a marked change (i.e., more severe) in relation to usual symptoms and signs, or unrelieved by measures already prescribed including any change in condition where the resident has difficulty breathing, low oxygen saturations, new onset cough, and congestion with decreased appetite and where emergent care needs can't be met at the facility.<br><br>The audit was completed on: [DATE]. The audit identified that 2 of 79 residents had an acute change in condition to include: Any symptom, sign or apparent discomfort that is: acute or sudden in onset, and is a marked change (i.e., more severe) in relation to usual symptoms and signs, or unrelieved by measures already prescribed including any change in condition where the resident has difficulty breathing, low oxygen saturations, new onset cough, and congestion with decreased appetite and where emergent care needs can't be met at the facility. On [DATE], correction action was completed to include notification of the provider of the resident change in condition and orders, transfer to ER, X ray, etc. No residents required transfer to an acute care hospital.<br><br>Specify the actions the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or reoccurring and when the action will be completed:<br><br>On [DATE] the Director of Nursing began in servicing all licensed nurses, Registered Nurses (RN) and Licensed Practical Nurses (LPN) and certified nursing assistants (full time, part time, and prn including agency) on assessment of any acute change in condition including how to respond to change in condition, how to assess a change in condition, when to activate Emergency Medical Services, what to do when a family makes a request to address a change in condition, and the importance of shift to shift report for continuity of care.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | The DON will ensure that all licensed nurses, RN's, LPN's, and CNA's (full time, part time, and prn including agency) who do not complete the in-service training by [DATE] will not be allowed to work until the training is completed.<br><br>This in-service was incorporated into the new employee facility and agency orientation for all licensed nurses and certified nursing assistants (full time, part time, and prn including agency) by the Director of Nursing.<br><br>Alleged date of IJ removal [DATE]<br><br>A validation of immediate jeopardy removal was conducted on [DATE]. The initial audit of residents was reviewed, and no issues were noted. Staff interviews across all departments were able to verbalize that they had received education on notification of change in condition, examples of change in condition, who to notify of a change in resident condition, etc. Non-nursing staff were able to verbalize examples of a change in condition and the appropriate steps to take in notification, including the hall nurse, Director of Nursing, Administrator, and medical provider. Nursing staff were able to verbalize steps to be taken when a resident was observed with a change in condition which included a thorough head to toe assessment, complete set of vital signs, assessment and vital sign documentation, and notification of a provider/initiation of Emergency Medical Services (EMS). The immediate jeopardy removal date of [DATE] was validated. |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50045<br><br>Based on observations, record review, Resident, staff, Nurse Practitioner (NP), and Medical Director (MD) the facility failed to have a documented diagnosis for the use of an indwelling urinary catheter (Resident #18) and facility failed to prevent urinary catheter bags from touching the floor to reduce the risk of infection (Resident #48) for 2 of 2 residents (Resident #18 and Resident #48) reviewed for urinary catheter.<br><br>The findings included:<br><br>1) Resident #18 was admitted to the facility on [DATE] with no urinary diagnosis.<br><br>A review of the physician's orders 2/13/2024 revealed an order for Resident #18 was to have an indwelling urinary catheter removed and replaced with a new catheter every 21 days and as needed for leaking or occlusion and was signed by the Medical Director (MD).<br><br>A review of a history and physical note dated 2/19/2024 completed by the MD revealed Resident #18 was admitted from the hospital due to a necrotic (dead tissue) lesion on his right foot which required amputation. Resident #18 was noted to have a wound vac. Resident #18 was not documented as having a urinary catheter. The MD documented Resident #18 had hematuria.<br><br>A review of the Treatment Administration Record from February 2024 to June 2024 revealed documentation that Resident #18 had his indwelling urinary catheter changed every 21 days as ordered.<br><br>A quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #18 was moderately cognitively impaired with no behaviors and was documented with an indwelling catheter.<br><br>A review of a care plan dated 5/20/2024 revealed Resident #18 had an indwelling urinary catheter.<br><br>An observation was conducted on 6/26/2024 at 12:26 pm Resident #18 had a urinary catheter hanging from the right-hand side of the bed. The urine in the catheter drainage collection bag was dark yellow with sediment (causes urine to be cloudy, white blood cell accumulation).<br><br>An interview was conducted on 6/26/2024 at 2:30 pm with Resident #18. Resident #18 stated he had a catheter for a while and was unsure of why he had one.<br><br>An interview was conducted on 6/26/2024 at 3:54 pm with Nurse #4. Nurse #4 reported was assigned Resident #18. Nurse #4 stated when a resident had a catheter, there should be an order. Nurse #4 stated she was not sure why Resident #18 had a urinary catheter and verified there was no diagnosis that would support a urinary catheter on Resident #18's Electronic Health Record (EHR).<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | An interview was conducted on 6/26/2024 at 5:10 pm with Nurse Supervisor #2. Nurse Supervisor #2 reported when a resident was admitted to the facility, an order should be in place for a urinary catheter if there is a supporting diagnosis. Nurse Supervisor #2 stated Resident #18 was admitted to the facility with a urinary catheter, and it had never been removed. Nurse Supervisor #2 verified there was no diagnosis in Resident #18's EHR to support the use of an indwelling urinary catheter.<br><br>An interview was conducted on 6/27/2024 at 4:19 pm with the MD. The MD stated a resident should have a supporting diagnosis such as urinary obstruction or retention for the use of an indwelling urinary catheter. The MD stated facility staff had contacted him on 6/26/2024 regarding Resident #18's urinary catheter and he could not find where an indwelling urinary catheter was warranted and ordered for the catheter to be removed.<br><br>An interview was conducted on 6/28/2024 at 11:27 am with the Nurse Practitioner (NP). The NP stated a resident should have a supporting diagnosis such as urinary retention for the use of an indwelling urinary catheter. The NP stated there was no actual diagnosis to support the use of an indwelling urinary catheter for Resident #18.<br><br>An interview was conducted on 6/28/2024 at 12:23 pm with the Interim Director of Nursing (DON). The Interim DON stated there should be an order for an indwelling urinary catheter with a urinary diagnosis. The Interim DON reported she was made aware on 6/26/2024 that Resident #18 had an indwelling urinary catheter without a urinary diagnosis and the urinary catheter was removed.<br><br>38515<br><br>#2. Resident #48 was admitted to the facility on [DATE] with diagnoses that included benign prostatic hyperplasia with lower urinary tract symptoms, and severe hydronephrosis of right kidney.<br><br>Review of Resident #48's significant change Minimum Data Set assessment dated [DATE] revealed him to be moderately impaired with no rejection of care. Resident #48 was coded as having an indwelling urinary catheter.<br><br>Review of Resident #48's physician orders revealed the following order:<br><br>- Indwelling urinary catheter size for severe hydronephrosis of right kidney; placed catheter during surgery. Catheter not to be removed until urology follow-up.<br><br>An observation completed on 06/25/24 at 2:31 PM revealed Resident #48 to be in his room, in bed. Resident #48's bed was observed to be lowered to the floor which resulted in his urinary drainage bag resting on the floor and folding over on itself. Nurse Aide (NA) #5 came in the room and covered Resident #48, walked around his bed and did not address the urinary drainage bag on the floor.<br><br>An interview with NA #5 on 06/25/24 at 2:35 PM revealed she did not notice the urinary drainage bag was on the floor and indicated she would raise the bed to keep it off the floor.<br><br>Another observation of Resident #48 completed on 06/28/24 at 8:34 AM revealed Resident #48 to be in his bed with his bed in the lowest position. An observation of Resident #48's urinary drainage bag revealed it to be detached from the bed and was lying flat on the floor.<br><br>(continued on next page) |

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| | 345045 | A. Building<br>B. Wing | 07/03/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| The Foley Center at Chestnut Ridge | 621 Chestnut Ridge Parkway<br>Blowing Rock, NC 28605 |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | An interview with NA #6 on 06/28/24 at 8:35 AM revealed she was assigned to Resident #48. NA #6 verified she had provided care to Resident #48 earlier that morning. NA #6 also reported urinary drainage bags should not rest on the floor and that it was the responsibility of nurse aides and nurses to ensure that urinary drainage bags were off the floor.<br><br>An observation of Resident #48's urinary drainage bag with NA #6 on 06/28/24 at 8:35 AM revealed it to be detached from his bed and was resting on the floor. NA #6 reported his urinary drainage bag should be attached to his bed and not in contact with the floor. NA #6 proceeded to hang the urinary drainage bag on Resident #48's bed and then raise his bed up until the urinary drainage bag was not in contact with the floor.<br><br>During an interview with the Acting Director of Nursing on 06/28/24 at 12:04 PM, she reported when a resident was in bed, it was her expectation that the urinary drainage bag be hung securely to the bed and if a resident was required to be in a low positioned bed, that their bed be lowered to the point where it kept the urinary drainage bag off the floor. She stated there was no reason for Resident #48's urinary drainage bag to not be attached to his bed and be left laying flat on the floor. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37280<br><br>Based on observations, record review, and staff interviews, the facility failed to have cautionary oxygen signage posted (Resident #15) and failed to keep an oxygen concentrator free from dust and debris (Resident #37) for 2 of 3 residents reviewed for respiratory care.<br><br>The findings included:<br><br>1. Resident #15 was admitted to the facility on [DATE] with diagnoses that included heart failure.<br><br>The admission Minimum Data Set assessment dated [DATE] revealed Resident #15's cognition was severely impaired, and she required supplemental oxygen.<br><br>A review of Resident #15's medical record revealed an order dated 05/28/24 for the hall nurse to wean oxygen via nasal cannula to maintain oxygen saturation above 92%.<br><br>On 06/25/24 at 1:02 PM during an observation of Resident #15, the Resident wore supplemental oxygen via nasal cannula at 0.5 liters per minute. There was no oxygen cautionary sign posted on or near the Resident's door to indicate oxygen was in use.<br><br>Subsequent observations of no cautionary sign posted on or near Resident #15's door on 06/26/24 at 2:56 PM and 06/26/24 at 4:22 PM.<br><br>An interview was conducted with Nurse #6 on 06/26/24 at 4:22 PM. The Nurse explained that all residents with oxygen should have oxygen cautionary signs posted on their doorframe to their rooms and as many times that she had been in and out of Resident #15's room, she never noticed there was no sign posted on her doorframe.<br><br>During an interview made with Nurse Supervisor #2 on 06/26/24 at 5:10 PM the Supervisor explained that all residents who wore oxygen should have cautionary oxygen signs posted on their doorframe to indicate a fire hazard because oxygen was in use. She stated the oxygen signs should be posted when the resident was admitted to the facility.<br><br>On 06/28/24 at 12:50 PM an interview was conducted with the interim Director of Nursing (DON) who explained the cautionary oxygen sign should be posted on the residents' door by the admitting nurse and if the resident transferred rooms, then the transferring nurse should post the sign. She stated that periodically, she would assign audits for the signs to be done but there had not been an audit done in a while. The interim DON stated there should be cautionary signs posted on all doors that have oxygen in use in the rooms.<br><br>38515<br><br>2. Resident #37 was admitted to the facility on [DATE] with diagnoses that included hypertensive heart disease and congestive heart failure.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review of Resident #37's quarterly Minimum Data Set assessment dated [DATE] revealed she was coded as receiving oxygen therapy while a resident.<br><br>Review of Resident #37's physician orders revealed the following orders:<br><br>- Oxygen at 2 liters per minute via nasal cannula as needed for shortness of breath. Use when oxygen saturations are 90% or less on room air.<br><br>- Clean oxygen concentrator filter once a week - every day shift, every Monday for oxygen use.<br><br>An observation of Resident #37 completed on 06/25/24 at 11:14 AM revealed her to be in bed resting with oxygen being provided via nasal cannula. An observation of Resident #37's oxygen concentrator at this time revealed the filter to be caked with white dust around the intake and filter.<br><br>An additional observation of Resident #37's oxygen concentrator was completed on 06/27/24 at 11:22 AM revealed the concentrator to continue to have a thick amount of white dust built up on the intake and filter.<br><br>Review of Resident #37's medication administration record (MAR) revealed Nurse #7 signed the MAR as having completed the cleaning of Resident #37's oxygen filter on 06/25/24.<br><br>Multiple attempts to reach Nurse #7 via telephone and text were unsuccessful.<br><br>An interview with NA #8 revealed she believed that the facility had a service company that came into the facility every so often and serviced the oxygen concentrators. She reported that it was her understanding that the service company would change the filters and repair any issues noted with the operation of the oxygen concentrators. She also reported she felt that the hall nurses were responsible for ensuring that the concentrators remained clean and free from dust and debris between the scheduled service.<br><br>An interview with Nurse #8 on 06/28/24 revealed she was an agency nurse and that she had worked in the facility approximately 3 shifts. She also reported she had nothing to do with the cleaning of oxygen concentrators and ensure they were free of dust and debris. She reported she had no knowledge of who was responsible for that task and assumed it was the unit managers.<br><br>An interview with Unit Manager #1 on 06/28/24 at 12:50 PM revealed it was her understanding that service and cleaning of oxygen concentrators was the responsibility of the Maintenance Director. She stated he would be the facility staff member responsible for ensuring that oxygen concentrators were clean from dust and debris.<br><br>An interview with the Maintenance Director on 06/28/24 at 12:54 PM revealed he coordinated with the service company the facility used to provide routine and emergency maintenance to the facility's oxygen concentrators. He further stated that he has nothing to do with the daily cleaning of the facility's oxygen concentrators. The Maintenance Director reported he did not know who was responsible for the daily cleaning of oxygen concentrators.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | An interview with the Acting Director of Nursing on 06/28/24 at 11:54 AM revealed she believed it was the responsibility of night shift staff to ensure that oxygen concentrator filters were clean and free from dust and debris. She reported the facility typically had standing orders in each resident's medical record to ensure the oxygen concentrators were clean and free from dust and debris. She also stated she expected oxygen concentrator filters to be clean and that there should be no build up of dust on them. |

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| F 0697<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide safe, appropriate pain management for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50045<br><br>Based on record review, Resident Representative (RR), staff, Nurse Practitioner (NP) interviews, the facility failed to address a resident's pain after a resident requested pain medication and was observed screaming in pain, crying, and very upset by Nurse #10 on [DATE]. The deficient practice occurred for 1 of 3 residents (Resident #279) reviewed for pain.<br><br>The findings included:<br><br>Resident #279 was admitted to the facility on [DATE] with a diagnosis of left artificial knee joint replacement.<br><br>A review of a physician's order dated [DATE] revealed an order for Resident #279 to be administered oxycodone (pain medication) 10 milligrams (mg) every four hours as needed for pain for 5 days. The order expired on [DATE].<br><br>A review of a physician's order dated [DATE] revealed an order for Resident #279 to be administered acetaminophen (pain medication) 1000 mg, every four hours as needed for general discomfort).<br><br>A review of the January and February 2024 Medication Administration Record (MAR) revealed documentation that Resident #279 received oxycodone 10 mg on [DATE] at 1:02 am (pain 8 out of 10) and 8:14 am (pain 2 out of 10); [DATE] at 10:17 pm (pain 7 out of 10); [DATE] at 10:05 am (pain 8 out of 10); and on [DATE] at 10:02 am (pain 5 out of 10) and 9:25 pm (pain 6 out of 10).<br><br>An admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #279 was cognitively intact with no behaviors.<br><br>A review of a nursing progress noted dated [DATE] at 8:40 pm, written by Nurse #10, revealed Resident #279 had requested oxycodone (pain medication) and there was not an active order for oxycodone (the order expired on [DATE]). Resident #279 was sitting on the side of the bed and grabbed the sides of her hair, began screaming, and demanded stronger pain medication than acetaminophen. The on-call provider was notified and advised staff to discuss the need for pain medication with the facility provider. No new orders for pain medication were received.<br><br>A review of a pain assessment dated [DATE] at 9:00 pm revealed Resident #279 had a pain level of 10 out of 10.<br><br>A review of the February 2024 MAR revealed documentation that Resident #279 received acetaminophen 1000 mg on [DATE] at 9:00 pm from Nurse #10.<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | An interview was conducted on [DATE] at 11:17 am with Nurse #10. Nurse #10 stated she worked night shift (7:00 pm to 7:00 am) and was assigned Resident #279 on [DATE]. Nurse #10 stated Resident #279 had requested oxycodone for pain, that she previously had been prescribed. Nurse #10 stated she checked Resident #279's active orders, and the order for oxycodone had expired. Nurse #10 stated Resident #279 started screaming in pain, crying, and was very upset. Nurse #10 stated she had contacted the on-call medical provider, name unknown, and requested an order for pain medication. Nurse #10 stated the on-call medical provider told her that Resident #279's pain medications would have to be obtained by a facility provider the following day. Nurse #10 stated Resident #279 continued to cry in pain for the remainder of her shift and stated she placed a communication sheet in the medical provider book to obtain a new order for pain medication. Nurse #10 reported she had checked on Resident #279 throughout the shift and assessed her for pain. Nurse #10 stated she had administered acetaminophen to Resident #279, but that Resident #279 continued to have pain. Nurse #10 stated she had not used ice, the night of [DATE], on Resident #279's left knee.<br><br>Resident #279 was unavailable for an interview.<br><br>An interview was conducted on [DATE] at 12:27 pm with Nurse Aide (NA) #3. NA #3 reported she was assigned Resident #279 on [DATE] during dayshift (7:00 am to 7:00 pm). NA #3 stated she was not able to recall Resident #279.<br><br>An attempt to interview NA #4, that was assigned Resident #279 on [DATE] during night shift (7:00 pm to 7:00 am) was unsuccessful.<br><br>An interview was conducted on [DATE] at 12:09 pm with Nurse #3. Nurse #3 reported she worked on [DATE] on dayshift (7:00 am to 7:00 pm) and was assigned Resident #279. Nurse #3 stated she remembered Resident #279 had a knee replacement surgery but was unable to recall Resident #279 complaining of pain.<br><br>An interview was conducted on [DATE] at 11:25 am with the Nurse Practitioner (NP). The NP stated she had seen Resident #279 following a knee replacement. The NP stated she had issues with pain following her surgery. The NP stated she was aware the on-call provider had refused to order pain medication for Resident #279 during night shift on [DATE] and reported she felt like the on-call provider should have given a one time order for pain medication to get the resident through the night until a facility provider could evaluate Resident #279 the next day. The NP stated she had noticed on-call providers were hesitant to prescribe pain medications and would often refer the staff to the regular facility providers. The NP stated she had written an order for Resident #279's oxycodone on [DATE].<br><br>A review of a physician's order dated [DATE] at 6:00 pm revealed an order for Resident #279 to be administered oxycodone 10 mg every six hours as needed for pain for 7 days.<br><br>A review of the February 2024 MAR revealed documentation that Resident #279 received oxycodone 10 mg at on [DATE] 6:00 pm (pain 0 out of 10) from Nurse #3.<br><br>An interview was conducted on [DATE] at 12:37 with Resident #279's Representative (RR). The RR stated Resident #279 was admitted to the facility following knee replacement surgery. The RR stated shortly after Resident #279 had issues getting pain medications and staff continued to tell her there were no orders for pain medication. The RR stated Resident #279 reported she was in pretty bad pain at times.<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | An interview was conducted on [DATE] at 12:18 pm with the Interim Director of Nursing (DON). The Interim DON stated she was aware of Resident #279 requesting pain medication on [DATE]. The Interim DON reported Nurse #10 had contacted on-call for a one-time pain medication order, and the on-call provider instructed Nurse #10 to have the regular facility provider order pain medication. The Interim DON reported this was not typical of the on-call providers and stated she had no explanation for why the provider had not ordered any pain medication. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50045<br><br>Based on record review, staff, and Nurse Practitioner (NP) interviews the facility failed to re-order medications from the pharmacy to ensure medications were available for 1 of 3 residents (Resident # 52) reviewed for the provision of pharmaceutical medications to meet residents' needs.<br><br>The findings included:<br><br>Resident #52 was admitted to the facility on [DATE] with a diagnosis of type 2 diabetes.<br><br>A review of a physician's order dated 4/12/2024 revealed Resident #52 was to be administered Humulin N Kwikpen (intermediate acting insulin, used to lower blood sugar levels) 8 units subcutaneously (injection) two times per day for diabetes, with instructions to hold if resident's blood sugar was less than 150 milligrams per deciliter (mg/dL).<br><br>A quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #52 was moderately cognitively impaired and had no rejections of care. Resident #52 was documented as having received 1 insulin injection during the 7 day look back period and was documented as having 0 number of days the physician changed the resident's insulin order during the 7 day look back period. Resident #52 was coded for hypoglycemic medications (medication used to increase a low blood sugar).<br><br>A review of the June 2024 MAR revealed Resident #52 had not received Humulin N Kwikpen 8 units subcutaneously on 6/22/2024 at 4:30 pm due to the medication not being available by Nurse #8.<br><br>A review of Resident #52's blood sugar levels revealed a reading of 200 mg/dL on 6/22/2024 at 4:55 pm.<br><br>A review of a nursing progress note completed by Nurse #3 dated 6/22/2024 at 6:26 pm revealed the on-call provider was notified that Resident #52's Humulin N Kwikpen was not in stock, provider was to call Nurse #3 back. The on-call pharmacist was notified that Humulin N Kwikpen would be needed the night of 6/22/2024.<br><br>A review of a nursing progress note dated 6/22/2024 at 8:22 pm completed by Nurse #8 revealed Resident #52 had not received insulin and was in route for delivery from the pharmacy.<br><br>An interview was conducted on 6/26/2024 at 4:32 pm with Nurse #3. Nurse #3 stated she worked 6/22/2024 on dayshift (7:00 am to 7:00 pm). Nurse #3 stated a Medication Aide, name unknown, informed her Resident #52 was out of insulin and there was no Humulin N Kwikpen's in the emergency medication back up. Nurse #3 stated she called the on-call medical provider and had to leave a message for them to return her call, and stated she called the emergency pharmacy and ordered more insulin that was to be delivered later that night. Nurse #3 stated she left her shift shortly after speaking with the emergency pharmacy and was unsure if Resident #52 received insulin later that night.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An interview was conducted on 7/2/2024 at 2:11 pm with Nurse #8. Nurse #8 reported he worked 6/22/2024 on night shift (7:00 pm to 7:00 am) and was assigned Resident #52. Nurse #8 reported he had been informed by the off-going Nurse that Resident #52 was out of insulin and there was none in back up. Nurse #8 stated he called the emergency pharmacy, and they delivered the medication around 8:00 pm, at which time he administered Resident #52's ordered dose of insulin. Nurse #8 stated he had forgotten to document the administration of Resident #52's insulin at 8:00 pm.<br><br>An interview was conducted on 6/28/2024 at 12:13 pm with the Interim Director of Nursing (DON). The Interim DON stated when a resident was running low on a medication, the Nurse should reorder the medication through their Electronic Health Record (EHR). The Interim DON stated if a resident was out of medication, the Nurse should pull the medication from the emergency backup. The Interim DON was unsure if Humulin N was kept in back up and stated facility staff should have ordered additional insulin when Resident #52 was observed to be low on insulin. |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure medication error rates are not 5 percent or greater.<br><br>50045<br><br>Based on observations, record review, staff, Nurse Practitioner (NP), and Medical Director (MD) interviews the facility failed to maintain a medication error rate of less than 5% by having 10 errors out of 25 opportunities which resulted in a 40% medication error rate. This affected 1 of 11 residents observed on medication pass (Resident # 286).<br><br>The findings included:<br><br>A review of Resident #286's 6/27/2024 active physician's orders revealed the following:<br><br>- Prednisone (steroid medication) 10 milligrams (mg) tablets, 2 tablets by mouth one time a day for COPD.<br><br>- Buspirone HCL (anxiety medication) 15 mg tablets, 2 tablets by mouth three times a day for anxiety.<br><br>- Sertraline (depression and/or anxiety medication) HCL 100 mg tablets, 2 tablets by mouth one time a day for depression.<br><br>- Levothyroxine Sodium (thyroid hormone medication) 150 micrograms (mcg) tablet once a day for hypothyroidism.<br><br>- Hydralazine HCL (medication used to treat high blood pressure) 50 mg tablet by mouth two times a day for hypertension (high blood pressure).<br><br>- Amlodipine Besylate (blood pressure medication) 10 mg tablet once a day for hypertension, hold if systolic (top number of blood pressure reading) is less than 120 mm/hg.<br><br>- Senna 8.6 mg tablet by mouth once a day for constipation.<br><br>- Omeprazole Magnesium 20 mg tablet by mouth once a day for heartburn.<br><br>- Guaifenesin 100 mg/5 ml Oral Syrup, 20 ml by mouth four times a day for COPD.<br><br>- Cyanocobalamin (vitamin B-12) 500 mcg tablet, 2 tablets once a day for a supplement.<br><br>An observation was conducted on 6/27/2024 at 10:14 am of Nurse #5 preparing Resident #50's medications. The medications that were prepared included aspirin (prevents blood clots from forming) 81 mg tablet, apixaban (blood thinner) 2.5 mg tablet, lactulose 15 ml oral solution, Lisinopril (blood pressure medication) 20 mg, senna (stool softener) 1 mg tablet, sertraline 25 mg tablet, tramadol (pain medication) 50 mg tablet, loratadine (allergy medication) tablet, and quetiapine (treats mood and behavior disorders) 25 mg tablet and Cranberry Supplement 450 mg tablet.<br><br>(continued on next page) |

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| | 345045 | A. Building<br>B. Wing | 07/03/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| The Foley Center at Chestnut Ridge | 621 Chestnut Ridge Parkway<br>Blowing Rock, NC 28605 |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | An observation was conducted on 6/27/2024 at 10:25 am of Nurse #5 taking Resident #50's medications to Resident #286's bedside. Nurse #5 told Resident #286, she had brought her morning medications and handed her the medication cup. Resident #286 proceeded to ask Nurse #5 what medications she was getting this morning and Nurse #5 reported she was unsure, and that she would have to go look and come back. Nurse #5 took the medications from Resident #50's hand and brought her computer to the bedside. Nurse #5 proceeded to hand Resident #286 the cup of medication while proceeding to say, okay {name of Resident #50}, you will be taking aspirin, a cranberry pill, and was stopped by Resident #286 when she asked, what did you say my name was? Nurse #5 replied {name of Resident #50). Resident #286 stated, that is not me, you have the wrong person. Nurse #5 replied what do you mean, you have the wrong person? Are you not {name of Resident #50}? Resident #286 stated, no I am {name of Resident #286}. Nurse #5 removed the cup from Resident #286 and left the room.<br><br>Nurse #5 administered Resident #286's correct medications.<br><br>An interview was conducted on 6/27/2024 at 10:33 am with Nurse #5. Nurse #5 reported she worked as an agency nurse in the facility. Nurse #5 stated residents should be verified by their name and date of birth prior to administering medications. Nurse #5 stated she was going to ask Resident #286 her name and date of birth and reported Resident #286 had intervened before should was able to. Nurse #5 stated she should have verified the resident's name and date of birth prior to handing her the cup of medication.<br><br>An interview was conducted on 6/27/2024 at 10:37 with the Interim Director of Nursing (DON). The Interim DON reported prior to administering medications, the Nurse should verify the right resident, right medication, right dose, right route, right date, and right time. The Interim DON stated Nurse #5 was an agency nurse and had just started working at the facility. The Interim DON stated Nurse #5 should have known to verify the rights of medication administration prior to attempting to give Resident #286 her medication.<br><br>An interview was conducted on 6/27/2024 at 1:02 pm with the NP. The NP stated several things could have happened if Resident #286 had received apixaban without a diagnosis of atrial fibrillation (irregular heart rate). She could have had bleeding. The NP stated, you should know the possible adverse effects of receiving the wrong medications and refused to answer further questions. The NP stated the encounter was not a medication error because Resident #286 had not received the medication.<br><br>An interview was conducted on 6/27/2024 at 4:21 pm with the MD. The MD stated medications should be given to the resident that they are ordered for. The MD was made aware of the observations on the medication pass with Resident #286. |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50045<br><br>Based on observations, record review, staff, Nurse Practitioner (NP), and Medical Director (MD) interviews the facility failed to verify medication rights of administration, including right resident and right medication, when a nurse attempted to administer Resident #50's medications (including apixaban, a blood thinner) to Resident #286 for 1 of 11 residents reviewed for significant medication error (Resident #286).<br><br>The findings included:<br><br>Resident #286 was admitted to the facility on [DATE] with a diagnosis of Chronic Obstructive Pulmonary Disease (inflammation of the lungs that decreases airflow), hypertension (high blood pressure), depression, anxiety, restlessness/agitation, acute embolism/thrombosis (blood clot) of a deep vein in the lower extremity, gastric ulcers.<br><br>An admission Minimum Data Set (MDS) assessment dated [DATE] was incomplete.<br><br>An observation was conducted on 6/27/2024 at 10:14 am of Nurse #5 preparing Resident #50's medications. The medications that were prepared included aspirin (prevents blood clots from forming) 81 mg tablet, apixaban (blood thinner) 2.5 mg tablet, Lisinopril (blood pressure medication) 20 mg, tramadol (pain medication) 50 mg tablet, and quetiapine (treats mood and behavior disorders) 25 mg tablet.<br><br>An observation was conducted on 6/27/2024 at 10:25 am of Nurse #5 taking Resident #50's medications to Resident #286's bedside. Nurse #5 told Resident #286, she had brought her morning medications and handed her the medication cup. Resident #286 proceeded to ask Nurse #50 what medications she was getting this morning and Nurse #5 reported she was unsure, and that she would have to go look and come back. Nurse #5 took the medications from Resident #50's hand and brought her computer to the bedside. Nurse #5 proceeded to hand Resident #286 the cup of medication while proceeding to say, okay {name of Resident #50}, you will be taking aspirin, a cranberry pill, and was stopped by Resident #286 when she asked, what did you say my name was? Nurse #5 replied {name of Resident #50). Resident #286 stated, that is not me, you have the wrong person. Nurse #5 replied what do you mean, you have the wrong person? Are you not {name of Resident #50}? Resident #286 stated, no I am {name of Resident #286}. Nurse #5 removed the cup from Resident #286 and left the room.<br><br>An interview was conducted on 6/27/2024 at 10:33 am with Nurse #5. Nurse #5 reported she worked as an agency nurse in the facility. Nurse #5 stated residents should be verified by their name and date of birth prior to administering medications. Nurse #5 stated she was going to ask Resident #286 her name and date of birth and reported Resident #286 had intervened before should was able to. Nurse #5 stated she should have verified the resident's name and date of birth prior to handing her the cup of medication.<br><br>(continued on next page) |

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|---|---|
| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An interview was conducted on 6/27/2024 at 10:37 with the Interim Director of Nursing (DON). The Interim DON reported prior to administering medications, the Nurse should verify the right resident, right medication, right dose, right route, right date, and right time. The Interim DON stated Nurse #5 was an agency nurse and had just started working at the facility. The Interim DON stated Nurse #5 should have known to verify the rights of medication administration prior to attempting to give Resident #286 her medication.<br><br>An interview was conducted on 6/27/2024 at 1:02 pm with the NP. The NP stated several things could have happened if Resident #286 had received apixaban without a diagnosis of atrial fibrillation (irregular heart rate). She could have had bleeding. The NP stated, you should know the possible adverse effects of receiving the wrong medications and refused to answer further questions. The NP stated the encounter was not a medication error because Resident #286 had not received the medication.<br><br>An interview was conducted on 6/27/2024 at 4:21 pm with the MD. The MD stated medications should be given to the resident that they are ordered for. The MD was made aware of the observations on the medication pass with Resident #286. The MD stated the medication that could have had an adverse outcome for Resident #286 would have been apixaban. The MD stated Resident #286 could have experienced unexpected bleeding. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38515<br><br>Based on observations and staff interviews, the facility failed to label and date open food items and discard items that were beyond their expiration date in 1 of 1 walk in refrigerators and 2 of 3 reach in refrigerators in the kitchen.<br><br>The findings included:<br><br>On an initial tour of the facility's kitchen on [DATE] at 10:17 AM, an open gallon of whole milk with a sell by date of [DATE] located in a reach-in refrigerator. An observation of the facility's 2nd of 3 reach-in refrigerators revealed open and undated package of American cheese slices and ,d+[DATE] block of open and undated butter with portions of the butter open to air. The cheese was wrapped in cellophane while the butter was in the original paper wrapping that was simply folded over the used end of the butter block.<br><br>During a follow-up visit to the kitchen on [DATE] at 11:58 AM an observation of the walk-in refrigerator revealed an open and undated bag of shredded mozzarella cheese with a use by date of [DATE].<br><br>An interview with the Dietary Manager on [DATE] at 12:01 PM she reported she goes through the refrigerators twice a week on Mondays and Thursdays to check for any open and undated food items or for any food items past their used by date or are expired. She stated that she expected her dietary staff to also check the refrigerators, freezers, or dry storage on Mondays and Fridays and remove any food items that are at or past their expired or used by date along with any food items that are opened and undated. She also explained that she expected her staff to always label and date any food items they open before they are stored away.<br><br>An interview with the Administrator on [DATE] at 12:49 PM revealed she expected food items to be removed at their expiration date and that she expected the dietary staff to always label and date opened food items before they are stored away. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>50045<br><br>Based on record review and staff interviews the facility failed maintain complete and accurate medical records by not ensuring the Nurse Practitioner completed a progress note after seeing a resident related to cough congestion and decreased appetite for 1 of 2 residents (Resident #278) reviewed for medical record accuracy.<br><br>The findings included:<br><br>A review of a provider communication form dated 1/23/2024 at 7:00 pm completed by Nurse #1 revealed Resident #278 presented with a cough, congestion and decreased appetite. Nurse #1 documented Resident #278's Resident Representative (RR) requested a chest x-ray and for the resident to be seen on 1/24/2024.<br><br>A review of Resident #278's progress notes revealed no documentation was written on 1/24/2024 by the Nurse Practitioner (NP).<br><br>An interview was conducted on 6/28/2024 at 11:12 am with the Nurse Practitioner (NP). The NP reported she had seen Resident #278 on 1/24/2024 per RR request at which time she noted Resident #278 had a cough and congestion and had not felt like a chest x-ray was warranted at that time. The NP stated she ordered Guaifenesin (oral medication for breaking up mucous/congestion) and Duo-neb (breathing treatment medication given through a nebulizer) treatments to treat the cough and congestion. The NP stated she had forgotten to finish and sign the note for Resident #278's encounter which is why the documentation was not in Resident #278's Electronic Health Record (EHR).<br><br>An interview was conducted on 6/28/2024 at 12:13 pm with the Interim Director of Nursing (DON). The Interim DON stated when a medical provider assesses a resident, a provider progress note should be in the EHR only if it was completed and signed. The Interim DON stated she had been made aware the NP had seen Resident #278 on 1/24/2024 and had not written/signed a note. The Interim DON verbalized a note should have been completed, signed, and uploaded into the medical record.<br><br>An interview was conducted on 6/28/2024 at 12:01 pm with the Administrator. The Administrator stated anytime a resident was seen by a medical provider in there facility there should be an accompanying signed note with each encounter. The Administrator was not aware the NP had seen Resident #278 on 1/24/2024 and not completed, signed, and uploaded a progress note into the EHR. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>37280<br><br>Based on observations, record reviews and interviews the facility failed to implement their handwashing/hygiene policy as part of their infection control program when Nurse #7 did not perform hand hygiene when changing gloves during wound care or change gloves after removing a soiled dressing from Resident #15. The facility also failed to implement their policy for Enhanced Barrier Precautions (EBP) regarding donning Personal Protective Equipment (PPE) to include donning gloves and gowns during high contact resident care activities. Two staff were observed checking Resident #15's brief for incontinence and were not wearing gowns or gloves during the incontinence check. These failures occurred for 1 of 3 residents (Resident #15) reviewed for infection control.<br><br>The findings included:<br><br>a. A review of the facility's Hand Hygiene policy as part of their Infection Control program revised 10/2022. Under policy indications for Hand Hygiene read in part:<br><br>*If hands are not visibly soiled, use an alcohol-based hand rub for routine decontaminating.<br><br>*Use hand hygiene after direct contact with resident's skin.<br><br>*After contact with bodily fluids or excretions, non-intact skin, wound dressings.<br><br>*After removing gloves.<br><br>*Before and after performing dressing care of touching wounds of any kind.<br><br>*After handling used dressings.<br><br>An observation of wound care was conducted on 06/27/24 at 11:40 AM by Nurse #7. The Nurse washed her hands and donned PPE of gloves and a gown. She exposed the resident's left heel that had a stage III pressure ulcer which was covered with a border dressing that was saturated with a moderate amount of brown drainage. Nurse #7 removed and discarded the saturated dressing in the trash can then removed her gloves and without washing her hands or using hand sanitizer the Nurse donned a clean pair of gloves. She then cleansed the left heel wound with wound cleanser spray and a single gauze pad then picked up the cleaning solution and poured the solution in a clear plastic cup and put a gauze pad in the solution to soak the gauze with the solution. Nurse #7 then removed the soaked gauze from the cup and squeezed out the excessive solution and placed the gauze against the left heel wound and covered the gauze with a border dressing. The Nurse then removed her gloves and donned a new pair of gloves without using hand sanitizer or washing her hands. The Nurse then dated the border dressing and replaced the resident's sock.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 06/27/24 at 2:13 PM an interview was conducted with Nurse #7 who explained she was an agency nurse who had been coming to the facility for years. The Nurse stated no management staff had audited her wound care technique, but she had been with supervisors before while performing wound dressing changes and had never been corrected on her technique. Nurse #7 acknowledged she did not wash or sanitize her hands when she changed her gloves and stated she did not know she was supposed to wash her hands in between glove changes and she did not know she should change her gloves after she removed the soiled dressing and after she cleaned the wound. The Nurse stated she was nervous while being watched during the procedure.<br><br>An interview was conducted with Nurse Supervisor #2 on 06/27/24 at 5:45 PM. The Supervisor explained that she rounded with the wound physician weekly and monitored the wounds along with the physician. The Supervisor indicated that hands should be washed or sanitized before and after donning and doffing gloves and after removing an old dressing, after cleansing the wound and before placing the new treatment to the wound. The Supervisor stated handwashing was a nurse thing and every nurse should know when to do it.<br><br>During an interview with the interim Director of Nursing (DON) on 06/28/24 at 1:03 PM the interim DON explained that she was new at the position and did not know how often or if the nurses were audited for proper technique in wound care dressing changes. She indicated her expectation was for the nurse to sanitize her hands after removing dirty gloves and donning clean gloves and she expected change their gloves after removing the old dressing and after cleaning the wound.<br><br>b. A review of the facility's Enhanced Barrier Precautions as part of their Infection Control program revised 03/2024 revealed in part:<br><br>Under Policy: It is the policy of this facility to use EBP based on guidance from the Centers for Disease Control (CDC). Enhanced barrier precautions expand use of Personal Protective Equipment beyond situations in which exposure to blood and body fluids is anticipated. Enhanced precautions refer to the use of gown and gloves during high contact resident care activities that provide opportunities for transfer of multi drug resistant organisms to staff hands and clothing.<br><br>Applies to all residents with the following:<br><br>*Wounds or indwelling medical devices.<br><br>Examples of high contact resident care activities requiring enhanced barriers:<br><br>*Incontinence care<br><br>*Wound care<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 06/26/24 at 2:56 PM Nurse #6 and Nurse Aide (NA) #3 were observed going into Resident #15's room to provide incontinent care. The Resident's door was marked with EBP signs posted outside the door and a drawer set was parked inside the door stocked with PPE available for use. The EBP signage was marked with directions to use gowns and gloves when rendering high contact resident care activities such as: changing briefs and assisting with toileting. Nurse #6 did not don gown or gloves and the NA only donned gloves after which both staff positioned the Resident to her left side. The Nurse proceeded to unfasten the Resident's brief to determine if the Resident was wet or soiled. The Nurse stated the Resident was dry and did not need to have her brief changed at that time. Both staff then repositioned the Resident to her back and left the room.<br><br>An interview was conducted with Nurse #3 on 06/26/24 at 4:22 PM who explained that she knew the Resident was on EBP, but she thought she only had to wear the PPE if she was going to change the Resident's wound dressing and not for the purpose of changing her brief.<br><br>During an interview with Nurse Aide #3 on 06/26/24 at 4:35 PM the NA explained that she was aware of EBP sign posted on Resident #15's door and thought the Resident was under the EBP because she had a urinary catheter. She continued to explain that she knew the Resident's catheter had been removed and thought the facility had not taken the EBP sign down and taken the PPE away yet and that was why she only wore gloves.<br><br>An interview was conducted with Nurse Supervisor #3 on 06/26/24 at 5:18 PM who explained that there were multiple indications for a resident to be under EBP and having a urinary catheter and a wound were indications for the precautions. The Supervisor reported Resident #15 did have a urinary catheter that was recently removed, and the Resident did have a current wound so the EBP should have been honored and the correct PPE should have been worn. The Supervisor stated her expectation was for the PPE to be worn no matter if the facility had not removed the signage yet.<br><br>During an interview with the interim Director of Nursing (DON) on 06/28/24 at 1:03 PM the interim DON explained that she expected the staff to follow the directions on the EBP signage if it was posted outside the resident's door no matter what the reason the precautions were indicated for.<br><br>An interview was conducted with the Administrator and the Regional Nurse Consultant on 06/28/24 at 4:03 PM. The Nurse explained that Nurse #7 should have washed or sanitized her hands between glove changes, and she should have changed her gloves when she moved from a dirty to clean procedure during the wound care process. The Nurse also indicated that staff should don the appropriate PPE if the EBP signage was posted on the door. |