

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345092	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2024
NAME OF PROVIDER OR SUPPLIER Willow Valley Center for Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 1900 W 1st Street Winston-Salem, NC 27104	

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 (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Actual harm Residents Affected - Few	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38920</p> <p>Based on record review, observation, resident, and staff interviews the facility failed to protect a resident's dignity (a) when the resident was left with 3 briefs on that were soiled and saturated with urine during the breakfast meal and (b) left to urinate in a brief after she had told a Nursing Assistant (NA) #10 she had to urinate. The resident voiced feeling dirty angry and neglected. This occurred for 1 of 1 resident (Resident #209) reviewed for incontinence care.</p> <p>Findings included:</p> <p>1 (a) Resident #209 was admitted to the facility on [DATE] with multiple diagnoses that included enterocolitis (inflammation in the intestines) and diabetes.</p> <p>The 5-day Minimum Data Set (MDS) dated [DATE] revealed Resident #209 was cognitively intact and required substantial to max assistance with toileting. The MDS documented Resident #209 with adequate vision and no issues with communicating. The MDS also documented Resident #209 was frequently incontinent of urine and always incontinent of bowel.</p> <p>Resident #209's care plan dated 5-23-24 revealed the resident had an activities of daily living (ADL) deficit due to enterocolitis and diabetes. The goal for Resident #209 was to improve the current level of ADL function. The interventions were one staff assist for personal hygiene and toileting. Resident #209 also had an intervention for two staff to assist the resident with transfers.</p> <p>Resident #209 was interviewed on 6-10-24 at 11:25am. Resident #209 was observed to be tearful and stated she was angry because she had been laying in a soiled and urine saturated brief since 8:15am. The resident explained she had put her call light on at 8:15am (stated she knew it was 8:15am because she looked at the clock on the wall) and asked NA #8 to be changed. She stated NA #8 told her she had to wait because the breakfast trays were arriving on the unit. Resident #209 said she told NA #8 again when she delivered her tray that she needed changed and stated NA #8 told her she would get changed after breakfast. Resident #209 said It is not right that I had to eat in this dirty brief and expressed this made her feel neglected and dirty. She stated she still had not been changed. The resident was observed to put her call light back on for assistance.</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Observation of incontinence care occurred on 6-10-24 at 11:33am with NA #4. During the observation, Resident #209 was observed to have 3 briefs and another brief was laid flat under her. When asked if she requested 3 briefs, Resident #209 stated no, the aide (NA #9) told me I had to have them on because I was a heavy wetter. It was observed that Resident #209's bowel movement and urine had seeped through all 3 briefs, the draw sheet, the cotton pad, and the fitted sheet. There were areas on the draw sheet, cotton pad, and fitted sheet that had dark yellow rings and on Resident #209's skin there were areas where her bowel movement had dried to her skin. The resident's skin was intact with no redness.</p> <p>NA #4 was interviewed on 6-10-24 at 11:44am. The NA explained she had come into work late, so she had not completed initial rounds on her assigned residents. She confirmed Resident #209 was assigned to her. NA #4 stated NA #8 had not informed her when she arrived that Resident #209 needed to be changed. When discussing the condition of Resident #209, NA #4 discussed that it was not normal practice to see 3 briefs on a resident and that due to the drying of urine and dried feces, NA #4 said she did not think the resident had been changed since the night before. NA #4 explained staff could change residents even when trays were being delivered and did not know why Resident #209 had not received incontinence care.</p> <p>During an interview with NA #8 on 6-10-24 at 11:50am, NA #8 explained the NA assigned to Resident #209 had come to work late so initial rounds were not completed on the resident. She stated at 8:15am, Resident #209 had put her call light on but said the resident never informed her she needed to be changed. When asked, NA #8 could not state what activity she provided the resident or what the resident wanted at 8:15am when she answered her call light. She also stated when she provided Resident #209 with her breakfast tray, the resident never told her she needed to be changed.</p> <p>A telephone interview occurred with NA #9 on 6-12-24 at 7:30am. The NA confirmed she had been assigned to Resident #209 on 6-9-24 during the 11:00pm to 7:00am shift. NA #9 explained she had usually changed Resident #209 every hour because she urinates a lot. She stated she had last changed Resident #209 between 6:00am and 6:30am on 6-10-24. NA #9 discussed Resident #209 asking for 2 briefs, but the NA stated she placed one brief on the resident and laid another one down flat under the resident. NA #9 stated she had not placed 3 briefs on the resident.</p> <p>A follow up interview occurred with Resident #209 on 6-12-24 at 10:33am. Resident #209 again stated she had not asked for extra briefs to be placed on her. She explained that NA #9 had told her she had to have 3 briefs on because she was a heavy wetter.</p> <p>(b) Observation and interview occurred with Resident #209 on 6-12-24 at 10:33am. The resident was observed wiggling in her bed. When questioned, Resident #209 stated she had to urinate. She explained she had put her call light on and when Nursing Assistant (NA) #10 arrived she had told the NA she had to urinate. Resident #209 explained NA #10 adjusted her brief and told her If you get the fitted sheet wet you will have to lay on just the mattress because we don't have any other fitted sheets. The resident said she has been holding her urine because she does not want to get her sheets wet. Resident #209 voiced feeling angry and neglected having to go to the bathroom in her brief when she could use a bed pan. When asked, Resident #209 stated she did not know why she was not taken to the bathroom or provided a bed pan. This surveyor left Resident #209's room and requested the unit manager come to the resident's room.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the unit manager occurred on 6-12-24 at 10:37am. This surveyor explained Resident #209's situation and the unit manager questioned why NA #10 did not provide a bed pan. The unit manager was observed going to Resident #209's room where Resident #209 explained the situation. The unit manager provided Resident #209 a bed pan. The unit manager stated any resident who was able to use a bed pan should be provided a bed pan and that it was not dignified to expect a resident to urinate in a brief when they are able to use the restroom or bed pan.</p> <p>During an interview with NA #10 on 6-12-24 at 10:41am, the NA confirmed she had answered Resident #209's call light. She explained the resident had informed her she needed to urinate, and that the resident had asked her to adjust her brief. NA #10 stated she adjusted the resident's brief and walked out. NA #10 discussed not thinking about giving the resident a bed pan, because she was wearing a brief, and the resident did not specifically ask for a bed pan or to go to the bathroom.</p> <p>The Director of Nursing was interviewed on 6-12-24 at 2:37pm. The DON discussed staff receiving yearly training on incontinence care, dignity, and resident rights. She stated staff were able to provide incontinence care if the meal trays were on the unit but that she would expect them to wash their hands prior to passing the trays. The DON discussed Resident #209 and stated no resident should have to eat their meal in a soiled and wet brief. She also stated it was not the facilities policy to apply more than one brief to a resident. The DON explained if the resident requested more than one brief, the resident would be care planned for more than one brief. She stated since Resident #209 was cognitive enough to know when she needed to use the restroom, she would have expected NA #10 to offer Resident #209 to go to the bathroom or a bed pan.</p> <p>The Administrator was interviewed on 6-12-24 at 4:32pm. The Administrator discussed it not being appropriate for a resident to have on more than one brief but also said she felt this may have been a one-time occurrence. She stated if Resident #209 urinated frequently, then she would expect the resident to be care planned for more frequent visits. The Administrator also discussed if a resident was aware enough to say they needed to use the bathroom, then NA #10 should have offered this to Resident #209 instead of expecting the resident to use the bathroom in a brief.</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20670</p> <p>Based on observations, resident and staff interviews, the facility failed to honor a resident's request to be assessed for smoking for 1 of 3 sampled residents (Resident #128) reviewed for choices.</p> <p>Findings included:</p> <p>Resident #128 was admitted to the facility on [DATE] with diagnoses which included osteomyelitis of vertebra, lumbosacral region, Parkinson's disease, and congestive heart disease.</p> <p>The admission Minimum Data Set, dated dated dated [DATE] indicated Resident #128 was cognitively intact.</p> <p>Review of the facility's Safe Smoking Screening dated 4/30/24 included Resident #128 did not currently smoke.</p> <p>During an interview on 6/11/24 at 1:09 p.m., Resident #128 revealed she was a smoker and since she was admitted to the facility had requested to be assessed to smoke. The resident stated smoking calmed her and she frequently begged staff (unable to name staff) to be assessed for smoking but was always told that staff did not have time to assess her for smoking.</p> <p>On 6/14/24 at 2:10 p.m. Nurse #2 revealed she completed the Smoking Assessment on Resident #128 during the admission process and documented the resident as not being a smoker. Nurse #2 was unable to recall if she asked the resident if she smoked. She insisted the resident never requested to smoke until she had a roommate who smoked. Nurse #2 stated she spoke with the nurse practitioner who felt the resident would not be a safe smoker. The resident must be able to hold a cigarette without burning herself, sit upright without increase in pain for more than a few minutes because of chronic pain related to a sacral wound and rheumatoid arthritis. The nurse practitioner offered nicotine patches which the resident refused. Nurse #2 admitted that once facility staff became aware Resident #128 requested to smoke, an updated smoking assessment should have been completed at that time.</p>

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<p>F 0569</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20906</p> <p>Based on staff interviews, family interview and record review of resident trust account, the facility failed to convey funds within 30 days to a discharged resident and failed to forward the balance of funds to the estate of an expired resident for 2 of 3 residents reviewed for personal funds (Resident #619 and 620).</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Resident #619 was admitted to the facility on [DATE] and expired on [DATE]. <p>Review of the resident trust account for Resident #619 revealed the amount of \$984.79 was not conveyed to the resident estate within 30 days of his death. The facility did not send the check to the Clerk of Court until [DATE].</p> <p>A telephone interview was conducted on [DATE] at 2:20 PM with Resident #619's family member who stated that Resident #619 died on [DATE] and when she contacted the facility regarding the remaining funds, she was given the run around that the money had been returned to the Medicaid office. She stated the previous Business Office Manager (BOM) continued to report the check would be sent to her being that she was the responsible person. She further stated the funds had not been sent to her and she had not received any correspondence from the facility about where the monies had been sent as of [DATE]. No one from the facility had informed her of the actual amount that would be refunded.</p> <p>An interview was conducted on [DATE] at 3:00 PM, in conjunction with a record review with the Business Office Manager who revealed the previous Business Office Manger had not sent out the check to the Clerk of Court within the designated 30 days. The Business Office Manager stated that it was not discovered until an audit was done at the end of [DATE] that the funds had not been forwarded to the Clerk of Court . The check was sent to the Clerk of Court on [DATE]. The Business Office Manager further stated after the completion of the audit and mailing of the check, the facility did not communicate or correspond with the family that the money in the amount of \$984.79 had been forwarded to the Clerk of Court.</p> <p>An interview was conducted on [DATE] at 9:15 AM, in conjunction with a record review with the Regional Business Office Director revealed the previous Business Office Manager failed to complete an audit and forward the funds to the Clerk of Court. The Regional Business Office Director stated the money should have been sent to the Clerk of Court within 30 days of death per policy. The discrepancy was not discovered until an audit was done at the end of [DATE] and the monies were sent in April following the audit.</p> <p>An interview was conducted on [DATE] 10:21 AM with the Administrator who stated the Regional Business Office Director and Business Office Managers were responsible for ensuring a financial record for expired and discharged residents were reviewed and audited monthly and all refunds dispersed to the proper agency, resident and/or representative in accordance with the federal regulations within 30 days.</p> <p>(continued on next page)</p>		

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<p>F 0569</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>2. Resident #620 was admitted to the facility [DATE] and discharged home [DATE].</p> <p>Review of the resident trust account for Resident #620 revealed the amount of \$1, 984.13, had not been refunded to the resident within 30 days of discharge.</p> <p>An interview was conducted on [DATE] at 3:00 PM, in conjunction with a record review with the Business Office Manager who revealed the previous Business Office Manager failed to send the refund within the designated 30 days. She stated the facility system failed due to the billing system not responding or providing monies to refund the resident in the amount of \$1, 984.13. The request was made on [DATE] to the home office for the funds however, no one responded as of [DATE]. Based on the audit and financial review, the previous Business Office Managers had not submitted a request for the refund when the resident was discharged . She further stated per policy discharged and expired residents' accounts should be reviewed and closed out and refunded to the resident or agency within 30 days per the conveyance policy.</p> <p>A telephone interview was conducted on [DATE] at 7:45 AM, with Resident #620's family member who stated she had requested from the previous Business Office Manager and assistant the return of funds from Resident #620's social security check be returned to her when she was discharged on [DATE]. She reported the previous Business Office Manager stated the check had been returned to the social security office and Medicaid, when the family contacted the social security office, they stated they had not received any correspondences from the facility about the discharge or the request for the social security check to be returned to the home address. She stated she again spoke with the previous BOM about the billing and address change for the check and he continued to give her the run around. She reported Resident #620 had several bills that were not paid for the month of April resulting in the delay of bills. She did not receive the reinstatement of the social security check until May. The family member further stated Resident #620 had not received any refund from the facility for the April check. She reported she had spoken with the current Business Office Assistant to resolve the issue and was told the money would be refunded in April and as of [DATE] she had not received any money.</p> <p>An interview was conducted on [DATE] 10:21 AM, with the Regional Business Office Manager who shared the Business Office Managers were responsible for ensuring a financial record for expired and discharged residents were reviewed and audited monthly and all refunds dispersed to the proper agency, resident and/or representative in accordance with the federal regulations.</p> <p>An interview was conducted on [DATE] 10:21 AM with the Administrator who stated the Regional Business Office Director and Business Office Managers were responsible for ensuring a financial record for expired and discharged residents were reviewed and audited monthly and all refunds dispersed to the proper agency, resident and/or representative in accordance with the federal regulations within 30 days.</p>		

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<p>F 0576</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Ensure residents have reasonable access to and privacy in their use of communication methods.</p> <p>31146</p> <p>Based on staff interview and resident council interview, the facility failed to deliver mail to residents on Saturdays for 211 Residents.</p> <p>The findings included:</p> <p>During an interview with 6 members of the Resident Council (Resident #20, Resident # 111, Resident #148, Resident #156, Resident #190 and Resident #365 on 6/13/24 at 9:30 am revealed they did not receive mail on Saturdays and the facility only delivered mail Monday through Friday.</p> <p>Interview with the Activities Director on 6/13/24 at 10:09 am revealed mail was sorted by the Business Office then given to the Activities Department to be delivered to residents. Activities delivered mail to residents 5 days a week, Monday through Friday. She stated mail was delivered to the facility on Saturdays, but the Business Office received the mail first.</p> <p>Interview with the Business Office Manager and Business Office Manager Assistant on 6/13/24 at 10:50 am revealed residents would receive packages on Saturday but not mail because the business office was closed. Mail was sorted and then given to the Activities Department to be delivered Monday through Friday when the business office was open. Mail was sorted to ensure the facilities mail was removed before giving mail to the Activities Department for delivery.</p> <p>Interview with the Director of Nursing on 6/13/24 at 3:18 pm revealed the Activities Department was responsible for delivering mail to residents. Mail should be delivered to residents on Saturdays.</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45276</p> <p>Based on observation, staff interviews, and record review the facility failed to maintain personal privacy by failing to prevent exposure of a resident's body parts during incontinence care for 1 of 3 residents (Resident #168) reviewed for personal privacy. The reasonable person concept was applied to this deficiency as individuals have the expectation of privacy during incontinence care.</p> <p>The findings included:</p> <p>Resident #168 was readmitted to the facility on [DATE].</p> <p>The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #168 was severely cognitively impaired for daily decision making and required extensive to total assistance by 1 staff for toileting needs.</p> <p>On 06/12/24 at 2:17 PM, an observation was conducted of the 500 hall. This surveyor, the Maintenance Director, and the Environmental Services Director observed Nurse Aide #1 (NA) provide incontinence care to Resident #168. The Resident's door was open, and the privacy curtain was not fully pulled around the bed to ensure his privacy. His bare buttocks were visible from the open doorway. NA #13 entered the room to assist NA #1 and did not close the door or pull the curtain fully around the bed to ensure privacy.</p> <p>An interview was conducted with NA #2 on 06/12/24 at 2:45 PM and she stated it was not standard procedure for the door and curtain to be open during incontinence care. She stated she did not think to close it as she walked into the room. She explained the door should have been closed and the privacy curtain should have been pulled. NA #2 stated the door latch was broken on Resident #168's room and that was why the door was open. She stated she had not put in a work order or report it to Maintenance.</p> <p>During an interview with Nurse #1 on 06/12/24 at 2:54 PM she stated the door and curtain should be closed in residents' rooms during incontinence care.</p> <p>An interview was conducted with NA #1 on 06/12/24 at 3:01 PM and she stated she knew the door was broken and usually propped something against it to keep it closed to provide privacy when giving care to the resident. She further stated she thought the privacy curtain was pulled far enough around the bed to block visibility from the hall. She added she should have made sure the door stayed shut and pulled the curtain further around the bed before incontinence care was provided to Resident #168.</p> <p>An interview was conducted with the Administrator on 06/14/24 at 2:37 PM and she stated NA #1 should have fully drawn the privacy curtain whether the door was in working order or not. She further stated if the resident had a roommate, the curtain afforded a second layer of privacy in case the roommate wanted to enter the room.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45276</p> <p>Based on observations and staff interviews the facility failed to maintain clean and sanitary floors and walls (bathroom of rooms #321 and #509), maintain clean and sanitary shower curtains (rooms #503, #509, #512, and #525), maintain clean and sanitary privacy curtains (rooms #302, #321, #503, #504, and #506), ensure the toilet was clean and in good repair (room [ROOM NUMBER]), maintain doors and walls in good repair (rooms #424, #517, #525, and #528), maintain privacy curtain ceiling tracks in good repair (rooms #504 and #506), maintain bathtubs/showers clean and in good repair (rooms #506, #507, #516, #517, and #525), maintain furniture in good repair (rooms #409, #513), and maintain the ceiling and polyvinyl chloride pipe (PVC) in good repair (room [ROOM NUMBER]) for 4 of 4 halls (200 hall, 300 hall, 400 hall, and 500 hall) reviewed for safe, clean, and homelike environment.</p> <p>The findings included:</p> <p>1. (a). Observations of room [ROOM NUMBER] on 06/10/24 at 11:45 AM and 06/11/24 at 10:00 AM revealed dried brown matter scattered across the bottom of the shower curtain. The observation further revealed the bracket from which the polyvinyl chloride pipe (PVC) hung was dislodged from the ceiling.</p> <p>(b). Observations of room [ROOM NUMBER] on 06/10/24 at 11:50 AM and 06/11/24 at 10:05 AM revealed stained privacy curtains hung loosely off the eyelet hooks on the left side of 504 A bed and the left side of 504 B bed due to not being properly attached to the ceiling tracks.</p> <p>(c). Observations of room [ROOM NUMBER] on 06/10/24 at 12:00 PM and 06/12/24 at 11:18AM revealed hundreds of small pieces of shredded purple confetti paper and a sticky residue under the bed of 321 B. Stained privacy curtains hung on the left side in the bed of 321 A bed and the left side in the bed of 321 B bed.</p> <p>(d). Observations of room [ROOM NUMBER] on 06/10/24 at 12:17 PM and 06/11/24 at 10:07 AM revealed stained privacy curtains privacy curtains on the left side, by the door, of 506 A bed and the left side of 506 B bed due to not being properly attached to the eyelet hooks in the ceiling tracks. The privacy curtain rod for 506 B bed was dislodged from the drywall. Observation of the shared bathroom revealed the tiles around bathtub faucet had been removed and the plumbing pipes inside of the wall were exposed.</p> <p>(e). Observations of room [ROOM NUMBER] on 06/10/24 at 12:19 PM and 06/11/24 at 10:17 AM revealed the shower head was broken off from the shower fitting and was lying in the tub.</p> <p>(f). Observations of room [ROOM NUMBER] on 06/10/24 at 12:49 PM and 06/11/24 at 9:39 AM revealed a stained privacy curtain on the window side of the room was not attached well and the bracket was loose from wall. The privacy curtain near resident's bed was soiled with brown stains along the bottom and sides of the curtain. There were brown splatters and streaks on the wall behind the toilet in the bathroom and on the shower curtain.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Willow Valley Center for Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 1900 W 1st Street Winston-Salem, NC 27104	
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>(g). Observations of room [ROOM NUMBER] on 06/10/24 at 1:18 PM and 06/11/24 at 10:24 AM revealed a stained shower curtain and dried smears of brown matter in the bathtub. There was a specimen collection container in the bathtub with dark amber matter in bottom. During the room observation on 06/10/24 the Resident's family member stated the brown matter on the wall, privacy curtain, shower curtain, and behind the toilet were from an episode of diarrhea the resident had experienced two weeks ago. She stated she had not expected there to still be feces on the wall when she arrived on 06/10/24.</p> <p>(h). Observations of room [ROOM NUMBER] on 06/12/24 at 8:46 AM and 06/12/24 at 4:00 PM revealed the vinyl wood grain veneer had peeled off the 3-drawer dressers on both resident's dressers. The middle drawer of 409 A's 3-drawer nightstand was missing and the bottom drawer of the nightstand had all the vinyl wood grain covering peeled off (exposing a plain yellow under surface).</p> <p>An interview was conducted with Housekeeper #2 on 06/11/24 at 10:07 AM while he cleaned room [ROOM NUMBER]. He stated the 500 hall was his assigned area for cleaning. He stated he swept and mopped each room daily. He further stated he disinfected the bathroom sink, toilet and bathtub in every resident room on the 500 hall daily. He said he had just completed his housekeeping duties for all rooms from 501through 514. When asked if he had swept, mopped, and disinfected the bedrooms and bathrooms for rooms 501through 514 he stated yes, completely.</p> <p>An interview and walking round were conducted with the Environmental Services Director and the Regional Director of Dietary and Environmental Services on 06/11/24 at 4:55 PM. Observations included the floors and walls of the bathrooms in rooms #321 and #509, the shower curtains in rooms #503, #509, #512, and #525, the privacy curtains in rooms #302, #321, #503, #504, and #506, the toilet in room [ROOM NUMBER], and the bathtubs/showers in rooms #506, #507, #516, #517, and #525. The Environmental Services Director stated routine cleaning of resident rooms included disinfecting all flat surfaces, sweeping and mopping the floor and bathroom floor, cleaning the bathroom sink, toilet, shower, and removing the trash. The Environmental Services Director stated all resident rooms were to be cleaned daily and as needed if the rooms needed further attention. The Environmental Services Director stated he expected bathrooms and resident rooms to be clean. He stated nursing staff were responsible for cleaning up any body fluids on the floor (blood, vomit, urine, and feces) and then environmental services staff disinfect the area after it has been cleaned. The Environmental Services Director and the Regional Director of Dietary and Environmental Services stated in-services on cleaning up body fluids on the floor will start immediately. They stated the stained shower curtains were being replaced.</p> <p>On 06/11/24 at 5:05 PM an interview was conducted with Nurse #1and she stated if a resident had diarrhea and it got on the floor, walls, or curtains the nursing staff cleaned visibly soiled areas and then housekeeping cleaned the rest. She stated this pertained to all other body fluids as well.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview and walking round were conducted with the Maintenance Director on 06/12/24 at 2:11 PM. During observations of the rooms on the 500 hall he stated he was not aware of the condition of the rooms including the toilet in room [ROOM NUMBER], the doors and walls in rooms #424, #517, #525, and #528, the privacy curtain ceiling tracks in rooms #504 and #506, the bathtubs/showers in rooms #506, #507, #516, #517, and #525, the furniture in rooms #409, #513, and the ceiling and polyvinyl chloride pipe (PVC) in room [ROOM NUMBER]. He stated any staff could and should put in a work order through the computer-based maintenance reporting program. He stated when a member of staff observed broken equipment or furniture in disrepair it should be reported through a work order. He stated information would be placed at the nursing station to remind staff to enter work orders promptly. He stated the furniture in disrepair would be replaced. He stated he and his assistant made weekly rounds to prioritize repairs. He stated repairs that impacted resident safety were completed first.</p> <p>On 06/14/24 at 2:00 PM an interview was conducted with the Administrator, and she stated she was trying to get all needed repairs and cleaning up to date. She stated she had removed a lot of the broken furniture and prioritized replacements. She stated there were more needed repairs. She said staff should enter needed repairs in the computer-based maintenance reporting program but if it is an item that could impact resident safety it would need to be removed immediately.</p> <p>38920</p> <p>2. Initial tour and subsequent follow up tours of hall 300 revealed the following.</p> <p>(a) room [ROOM NUMBER] was observed on 6-10-24 at 9:57am. The floor was noted to be dirty with brown and orange particles and pieces of paper.</p> <p>On 6-11-24 at 8:32am, room [ROOM NUMBER] still had brown and orange particles as well as paper on the floor.</p> <p>Housekeeper #1 was interviewed on 6-11-24 at 8:34am. The housekeeper confirmed hall 300 was her assignment and explained she was not working yesterday (6-10-24). She explained when she was not working, management should assign another person to clean the hall. The housekeeper stated there were housekeeping staff on the weekends and should be emptying trash, cleaning the tables, sweeping, mopping and cleaning the bathrooms as she stated she completed each day.</p> <p>Observation of room [ROOM NUMBER] occurred on 6-11-24 at 8:38am directly after housekeeper #1 finished cleaning the room. The room was observed to still have brown and orange particles as well as paper on the floor.</p> <p>Housekeeper #1 observed room [ROOM NUMBER] with surveyor on 6-11-24 at 8:42am. The housekeeper stated, what did not come up needs to be scrapped and I do not have a scrapper. When showed the debris was not stuck to the floor, housekeeper #1 had no response.</p> <p>A fourth observation of room [ROOM NUMBER] occurred on 6-12-24 at 1:24pm with the Environmental Service Manager and the Maintenance Director. The room continued to have debris (brown/orange particles, paper) under the over the bed table, around the trash can, next to/under the bed, and in the corners.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The Environmental Service Manager was interviewed on 6-12-24 at 1:25pm. The Environmental Service Manager stated the housekeepers are responsible for sweeping and mopping the floors. He explained his assistant conducted room to room morning rounds and if there were issues, he would speak to the housekeeper assigned to that room. When discussing the issues found, the Environmental Service Manager stated he did not believe his assistant was performing the rounds as he was supposed to.</p> <p>(b) During an initial observation of room [ROOM NUMBER], the room was observed to have an orange substance down the front of the heat/air unit, the floor had a yellow/orange substance that was sticky by the bathroom door, and there was debris on the floor that included food particles, paper, medicine cups, and dust.</p> <p>Another observation of room [ROOM NUMBER] occurred on 6-12-24 at 1:27pm with the Environmental Service Manager and the Maintenance Director. The room had orange substance down the front of the heat/air unit, the floor had a yellow/orange substance by the bathroom door, and there was debris on the floor that included food particles, paper, medicine cups, and dust.</p> <p>The Environmental Service Manager was interviewed on 6-12-24 at 1:28pm. The Environmental Service Manager stated the housekeepers are responsible for cleaning the front of the air/vent units. He stated he did not know why this had not been cleaned.</p> <p>(c) room [ROOM NUMBER] was observed on 6-10-24 at 10:42am. The privacy curtains in the room were observed to have 4 areas of a brown substance smeared on the curtain.</p> <p>On 6-12-24 at 1:30pm, a second observation was made of room [ROOM NUMBER] with the Environmental Service Manager and the Maintenance Director. The privacy curtains were observed to have 4 areas of a brown substance smeared on the curtain.</p> <p>The Environmental Service Manager was interviewed on 6-12-24 at 1:31pm. The Environmental Service Manager explained that HK was supposed to check the curtains for cleanliness and tell him if they needed to be cleaned. He also stated if staff saw the curtains were dirty, they could inform housekeeping so they could get them clean. The Environmental Service Manager stated he did not know why this was not completed.</p> <p>(d) An initial observation of room [ROOM NUMBER] occurred on 6-10-24 at 1:11pm. The room was observed to have paper, food particles, and an orange substance on the floor and a brown substance caked on the side rails of the resident's bed.</p> <p>A second observation of room [ROOM NUMBER] occurred on 6-11-24 at 11:09am. The room was observed to have been swept and mopped as the floor was still wet. However, the brown substance remained caked on the resident's side rails.</p> <p>During a third observation of room [ROOM NUMBER] occurred on 6-11-24 at 2:59pm. The observation revealed the caked on brown substance on the resident's side rails were still present.</p> <p>A fourth observation of room [ROOM NUMBER] occurred on 6-12-24 at 1:33pm with the Environmental Service Manager and the Maintenance Director. The observation revealed the caked on brown substance on the resident's side rails were still present.</p> <p>(continued on next page)</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The Environmental Service Manager was interviewed on 6-12-24 at 1:34pm. The Environmental Service Manager explained that housekeeping would not clean up urine or feces. He explained nursing staff would perform the initial cleaning of the feces and then housekeeping would follow by disinfecting the area. The Environmental Service Manager stated he did not know if the brown substance was feces so housekeeping should have wiped down the resident's side rails.</p> <p>(d) room [ROOM NUMBER] was observed on 6-10-24 at 12:36pm. The observation revealed metal showing where the plaster and paint had been stripped away, the floor had a yellow/clear substance on the floor that was sticky, and there was a hole approximately 1 inch by 1 inch in the middle of the bathroom door.</p> <p>A follow up observation of room [ROOM NUMBER] occurred on 6-12-24 at 1:36pm with the Environmental Service Manager and the Maintenance Director. The observation revealed the yellow/clear substance had been cleaned however the metal was still showing where the plaster and paint had been stripped away and there was a hole approximately 1 inch by 1 inch in the middle of the bathroom door.</p> <p>The Environmental Service Manager was interviewed on 6-12-24 at 1:37pm. The Maintenance Director discussed having one person assigned to plaster and paint but said he did not know if he was aware of the issues in room [ROOM NUMBER].</p> <p>(e) During a resident interview and observation of room [ROOM NUMBER] on 6-10-24 at 10:13am, the resident stated he was able to use the bedside commode but on Saturday (6-8-24) he stated he had a bowel movement on the floor by the bedside commode. Upon observing the room, the bowel movement was present under/behind the bedside commode. The resident stated staff were aware because he told them but said he could not remember who he told.</p> <p>Another observation of room [ROOM NUMBER] on 6-11-24 at 8:16 revealed there was still feces on the resident's floor under/behind the bedside commode.</p> <p>NA #18 was interviewed on 6-11-24 at 8:20am. The NA confirmed she had worked the weekend with the resident but stated she was not aware he had a bowel movement on the floor.</p> <p>A third observation on 6-11-24 at 11:00am, after the housekeeper was seen cleaning the resident's room, revealed remanence of feces under/behind the bedside commode.</p> <p>A fourth observation of room [ROOM NUMBER] occurred on 6-12-24 at 1:39pm with the Environmental Service Manager and the Maintenance Director. The observation revealed a brown/orange area where the feces had been under/behind the resident's bedside commode as well as red/orange debris under his bed and food particles on the floor.</p> <p>The Environmental Service Manager was interviewed on 6-12-24 at 1:40pm. The Environmental Service Manager discussed starting training with the housekeeping staff on how to properly clean a resident's room. He stated the training started yesterday (6-11-24) but that the housekeeper for hall 300 was not present.</p> <p>(f) room [ROOM NUMBER] was observed on 6-10-24 at 11:02am. The room was observed to have an approximately 2 foot wide by 2.5-foot-long area of a yellow dry sticky substance at the head of the bed. There were also brown and orange substances on the resident's wall next to her bed.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A follow up observation of room [ROOM NUMBER] occurred on 6-12-24 at 1:41pm with the Environmental Service Manager and the Maintenance Director. The follow up observation revealed remanence of the yellow substance and the brown and orange substances on the resident's wall next to her bed remained present.</p> <p>The Environmental Service Manager and the Assistant Administrator were interviewed on 6-12-24 at 1:43pm. The Environmental Service Manager discussed that housekeeping was supposed to be checking the walls for any spills or dirt and cleaning any area that contained an issue. The Environmental Service Manager stated he had not been aware of the issues discussed during the observations. The Assistant Administrator stated she believed there was a disconnect between what the facility felt was clean and what the Environmental assistant believed to be clean.</p> <p>The Director of Nursing (DON) was interviewed on 6-12-24 at 3:04pm. The DON stated she could not speak to the environment but stated the Environmental Service Manager was new to the building. The DON also stated the nursing staff were aware they were responsible for cleaning any urine or feces first then contacting housekeeping to disinfect. She stated she did not know why feces had stayed on the resident's floor for days.</p> <p>The Administrator was interviewed on 6-12-24 at 5:09pm. The Administrator discussed housekeeping staff needing to identify those residents who require more frequent cleaning and develop a cleaning schedule. She also discussed that there were assigned staff to perform ambassador rounds each morning in the resident rooms and stated if the ambassador was not catching the issues, then staff or housekeeping should. The Administrator explained If a staff member (ambassador, nursing, maintenance) saw any issues, she would expect them to report the issue to the proper staff so the issue can be resolved.</p> <p>20906</p> <p>3.a. Observation was conducted on 6/11/24 at 12:42 PM, room [ROOM NUMBER] there were several pieces of tile missing from the back wall in the bathtub.</p> <p>b. Observation was conducted on 6/11/24 at 12:47 PM, room [ROOM NUMBER] there was no drain faucet in the bathtub.</p> <p>c. Observation was conducted on 6/11/24 at 12:48 PM, room [ROOM NUMBER], the closet doors and drawers were broken apart. The floor was very sticky, heavily stained and a very strong urine odor was present. There was stained dried liquids and old food under resident beds and around dresser and closet area.</p> <p>An interview was conducted on 6/12/24 at 2:27pm, the Maintenance Director stated work orders are put into the maintenance work order program which generated a work list. He further stated he did not have a complete list of repairs that needed to be done throughout the facility. The assigned maintenance staff for each of the floors were responsible for doing rounds and completing the needed repairs in resident rooms such as shower heads, tiles in bathrooms should be reported to maintenance the work order system. He indicated he did not have a system in place to monitor the repairs.</p> <p>42007</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. An observation was conducted on 6/11/24 at 12:30 PM, room [ROOM NUMBER] showed 5 feet of baseboard trim lying on the floor and not attached to the drywall. The inside of the bathroom door had deep, large scrapes dug into the bottom quarter of the door exposing rough wood door grain. There were also deep, large gouges into the wall just inside of the bathroom on the right-hand side exposing the drywall. Further inspection of the bathroom revealed the faucet in the bathtub was running. The faucet handles were in the off position.</p> <p>During an interview with the resident in bed A, whose quarterly Minimum Data Set assessment dated [DATE] had him as cognitively intact, on 6/11/24 at 12:40 PM, he stated that maintenance had fixed the trim on the baseboard several weeks ago, but it didn't stay that way for long before it fell off again. He also stated that the bathtub faucet had been running for several days. He stated that he mentioned it to several aides, but nothing had been done to fix it.</p> <p>An interview and observation were conducted with the Administrator on 6/11/24 at 1:24 pm in room [ROOM NUMBER]. She stated that she was unaware of the issues in that room and was also unaware that the resident in bed A had attempted to bring it to the attention of staff multiple times. She stated that she would see to it that maintenance was made aware of the issues immediately.</p> <p>An interview was conducted on 6/13/24 at 3:34pm, the Maintenance Director stated the nursing staff would enter needed repairs into the computerized system that would notify him and his staff. He stated they would print out the work repair requests and assign the tasks to maintenance staff assigned to each floor who were supposed to be doing weekly rounds for all areas including resident rooms. He stated he was not aware of the issues in room [ROOM NUMBER] and was also not aware that the bathtub faucet was running. He stated that the system currently in place was for maintenance workers to check their assigned floor for any issues.</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45276</p> <p>Based on record review, family interviews, and staff interviews the facility failed to record a grievance and to make efforts to resolve the grievance for 1 of 3 residents reviewed for grievances (Resident #36).</p> <p>Findings include:</p> <p>Resident #36 was readmitted on [DATE].</p> <p>Review of Resident #36's most recent Minimum Data Set (MDS) revealed a quarterly assessment with an Assessment Reference Date (ARD) of 04/19/24. The resident was coded as having severe cognitive impairment.</p> <p>During a phone interview with the guardian of Resident #36 on 06/13/24 at 11:43 AM she stated she had visited Resident #36 on 06/07/24 and observed that Resident #36's roommate removed his brief and shredded the brief into many pieces. She stated she observed the roommate masturbate and play in the feces from the shredded brief during her visit. The guardian stated she sent an email to Social Worker (SW) Assistant #1 to inform her of Resident #36's roommate's behavior and to request moving Resident #36 to another room. The guardian stated on 06/10/24 she received an email from SW Assistant #1 informing her she (SW Assistant #1) would let the Director of Nursing (DON) and the Unit Manager (UM) know of the concern. The guardian stated she replied to SW Assistant #1's email and asked for a response on how the concern would be resolved. The guardian said she received no further written or oral communication from the facility regarding the result of the investigation from her grievance.</p> <p>An interview was conducted with SW Assistant #1 on 06/13/24 at 2:11 PM. SW Assistant #1 stated she received an email from Resident #36's guardian on 06/07/24. She said she responded to the email on 06/10/24 and forwarded the email to the DON and UM. She stated she sent a response to the guardian that she would inform the DON and UM of the guardian's concerns. She stated she and the UM were brainstorming to figure out which residents would be compatible to switch. She stated there was not an unoccupied bed to which Resident #36 could be moved. She stated she did not have a resolution at this time unless the guardian wished to move Resident #36 to another floor if they could find another resident with whom to switch rooms. When asked if she had consulted with the guardian regarding a solution she stated no. She said she thought the DON or UM would complete the grievance, resolve the guardian's concern and follow up with the guardian. She added anyone can fill out a grievance form, but she did not on this occasion.</p> <p>An interview was conducted with the DON on 06/13/24 at 2:30 PM. The DON stated she had not read her emails since 06/10/24 due to the recertification survey. She stated she did have an unread forwarded email from SW Assistant #1 dated 06/07/24. The DON stated she was not verbally informed of the guardian's concern. She stated a Grievance/Concern form should have been initiated by SW Assistant #1 on the day the email was received. She stated SW Assistant #1 should have followed up with the guardian by email and via telephone immediately on 06/10/24 to let her know the concern was being addressed.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility grievances on 06/14/24 at 2:30 PM revealed no recorded grievance for Resident #36 had been completed.</p> <p>An interview was conducted with the Administrator on 06/14/24 at 2:45 PM. The Administrator stated SW Assistant #1 should have immediately completed a grievance form when she received the email from the guardian on 06/10/24. She stated grievances/concerns needed to be documented on the Grievance/Concern form and followed through upon as part of the grievance process, which includes providing a copy of the Grievance/Concern Form to the resident/resident representative upon resolution of the grievance/concern.</p>		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>38920</p> <p>Based on observation, record review, staff, and resident interviews, the facility failed to protect a resident's right to be free from neglect when Resident #209 was (a) left with 3 briefs on that were soiled and saturated with urine during the breakfast meal and (b) left to urinate in a brief after she had told a Nursing Assistant (NA) #10 she had to urinate. The resident voiced feeling dirty angry and neglected. This occurred for 1 of 1 resident (Resident #209) reviewed for neglect.</p> <p>Findings included:</p> <p>This tag is cross referenced to:</p> <p>F550: Based on record review, observation, resident, and staff interviews the facility failed to protect a resident's dignity (a) when the resident was left with 3 briefs on that were soiled and saturated with urine during the breakfast meal and (b) left to urinate in a brief after she had told a Nursing Assistant (NA) #10 she had to urinate. The resident voiced feeling dirty angry and neglected. This occurred for 1 of 1 resident (Resident #209) reviewed for incontinence care.</p> <p>The Administrator was interviewed on 6-12-24 at 4:32pm. The Administrator stated NA #8 had answered Resident #209's call light at 8:15am but had not changed the resident but said if Resident #209 needed incontinence care provided at that time NA #8 should have provided the care.</p>		

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NAME OF PROVIDER OR SUPPLIER Willow Valley Center for Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 1900 W 1st Street Winston-Salem, NC 27104	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38920</p> <p>Based on record review, resident and staff interviews, the facility failed to complete and submit an Initial Allegation Report within 2 hours to the State Regulatory Agency for 1 of 1 resident (Resident #209) reviewed for neglect.</p> <p>Findings included:</p> <p>Resident #209 was admitted to the facility on [DATE].</p> <p>The 5-day Minimum Data Set (MDS) dated [DATE] revealed Resident #209 was cognitively intact and required substantial to max assistance with toileting.</p> <p>Upon interviewing Resident #209 on 6-10-24 at 11:25am, the resident voiced feeling dirty, neglected, and angry being left in 3 briefs that were soiled and urine soaked while she ate her breakfast meal.</p> <p>The Administrator was informed on 6-12-24 at 4:32pm by this surveyor of Resident #209's feelings of neglect, angry, and dirty' when the resident was left in 3 briefs, that were soiled, and urine soaked while she ate breakfast.</p> <p>A telephone interview on 6-18-24 at 11:17AM with the Administrator stated she had not completed an Initial Allegation Report and they had investigated the situation. She stated there had not been a resolution to the investigation as to why Resident #209 had on 3 briefs and not provided incontinence care. She stated she had not reported the allegation as neglect to the state agency.</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20670</p> <p>Based on record reviews and Ombudsman and staff interviews, the facility failed to provide written notification to the ombudsman of the transfer of 1 of 3 sampled residents (Resident #265) to the hospital. This practice had the potential to affect other residents discharged .</p> <p>Findings included:</p> <p>Resident #265 was originally admitted to the facility on [DATE].</p> <p>The annual Minimum Data Set, dated dated dated [DATE] indicated Resident #265 was cognitively intact.</p> <p>Review of the clinical records revealed Resident #265 was transferred to the hospital on 5/10/24</p> <p>per his request and physician's order related to pain and discomfort in his bilateral lower extremities. The resident was subsequently admitted to the hospital. There was no documentation indicating a written notice of transfer was provided to the ombudsman.</p> <p>A telephone interview with the Ombudsman on 6/13/24 at 9:24 a.m. revealed she had not received any of the facility's May 2024's discharge summaries, including Resident #265's discharge to the hospital on 5/10/24.</p> <p>During an interview on 6/13/24 at 9:39 a.m., the facility's Director of Social Work stated that it was her responsibility to send the Ombudsman a monthly list of discharged residents with their locations. She explained she usually emailed the list on the last day of every month or the beginning of the next month. After reviewing her emails, the Director of Social Work acknowledged she had not sent the Ombudsman the list and notices of residents when discharged from the facility in the month of May 2024. The most recent email the Director of Social Work sent to the Ombudsman was on 4/11/24 of a list of residents discharged in March 2024.</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32394</p> <p>Based on record reviews and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment related to the Preadmission Screening and Resident Review (PASRR) Level II status for 1 of 4 residents (Resident #174) reviewed for PASRR.</p> <p>The findings included:</p> <p>Resident #174 was admitted to the facility on [DATE] with a cumulative diagnosis which included paranoid schizophrenia.</p> <p>Resident #174's most recent comprehensive Minimum Data Set (MDS) was an annual assessment dated [DATE]. The Identification Information section of this MDS assessment did not report Resident #174 had a PASRR Level II determination.</p> <p>Further review of the resident's electronic medical record (EMR) revealed Resident #174's care plan included the following area of focus, in part: The resident has a Level II PASRR related to serious mental illness (Initiated 8/3/23; Revised 4/2/24).</p> <p>An interview was conducted on 6/13/24 at 10:35 AM with the facility's Director of Social Work (SW). Upon request, the Director of SW reviewed Resident #174's medical record and provided a copy of the resident's PASRR Level II Determination Notification letter dated 4/17/23. This letter confirmed Resident #174 was determined to have PASRR Level II status.</p> <p>An interview was conducted on 6/13/24 at 3:25 PM with the facility's on-site MDS Nurse (MDS Nurse #1). During the interview, the MDS Nurse reported she was only responsible to conduct the MDS assessments on newly admitted residents. She also stated the facility utilized remote nursing staff to complete the remainder of the residents' MDS assessments.</p> <p>An unsuccessful attempt was made on 6/14/24 at 9:40 AM to conduct an interview with the remote MDS Nurse (MDS Nurse #2) identified as having completed the Identification Information Section on the 3/4/24 MDS related to PASRR status for Resident #174.</p> <p>An interview was conducted with the facility's Director of Nursing (DON) on 6/14/24 at 12:55 PM. During the interview, the inaccurate reporting of Resident #174's PASRR status on her 3/4/24 annual MDS assessment was discussed. In response, the DON indicated the resident's MDS assessment needed to be coded accurately.</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31146</p> <p>Based on record reviews and staff interviews the facility failed to submit a request for an evaluation for an updated Preadmission Screening and Resident Review (PASRR) determination 3 of 4 residents (Resident #37, Resident #102 and Resident #103) reviewed for PASRR. Resident #37, Resident #103 and Resident #102 received a new mental health diagnosis following admission.</p> <p>The findings included:</p> <p>1. Resident #37 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included traumatic brain injury (TBI), dementia with agitation and major depressive disorder. Upon re-admission, Resident #37 had a Level I PASRR number.</p> <p>Review of Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #37 was cognitively intact. The MDS further revealed the resident had no behaviors during the look back period.</p> <p>Nursing note dated 10/19/23 and authored by Nurse # 11 revealed Resident #37 had increased agitation. Further review of the nursing note revealed Situation, Background and Assessment (SBAR) for providers. The situation stated a change in condition were behavioral symptoms to include agitation and psychosis.</p> <p>Nursing progress note dated 11/8/23 and authored by Nurse #2 revealed Resident #37 was having behaviors of hallucination and being aggressive because of the hallucinations. The note continued with orders to refer the resident to psychiatry, give 1 time dose of Haldol (an anti-psychotic medication) 1 milligram (mg) and lab work to include complete blood count (CBC), comprehensive metabolic panel (CMP).</p> <p>Physician order dated 11/8/23 stated Haloperidol tablet 1mg. Give 1 tablet by mouth one time only for mood/aggressive behaviors until 11/8/23.</p> <p>Behavior note dated 2/19/24 and authored by Nurse #6 revealed Resident #37 was noted being aggressive with a visitor.</p> <p>Physician order dated 2/19/24 revealed Haloperidol lactate injection solution 5mg/ml (milliliter). Inject 2.5mg intramuscularly (IM) one time only for agitation and aggressiveness for 1 day.</p> <p>Care Plan dated 3/4/24 revealed Resident #37 had the potential to be verbally aggressive (resident hit/punching others) related to dementia, ineffective coping skills, mental/emotional illness, poor impulse control and resident had a history of Post Traumatic Stress Disorder (PTSD). The goals included Resident #37 would demonstrate effective coping skills and Resident #37 would verbalize understanding of need to control verbally abusive behavior. The interventions included psychiatric/psychogeriatric consult as indicated and when the resident became agitated intervene before agitation escalates; bide away from source distress, engage calmly in conversation; if response is aggressive staff to walk calmly away and approach later.</p> <p>(continued on next page)</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Behavior note dated 3/3/24 and authored by Nurse #9 revealed the Resident #37 made inappropriate sexual remarks to the Medication Aide and verbalized delusional thoughts regarding implants in his ear and being ambushed by a family member.</p> <p>Quarterly MDS assessment dated [DATE] indicated Resident #37 was cognitively intact, had no behaviors during the look back period and had a diagnosis that included Post Traumatic Stress Disorder.</p> <p>Behavior note dated 5/24/24 and authored by Nurse #10 revealed Resident #37 went into two resident rooms and demanded the residents turn their tv's off. Resident #37 was educated that he could not go into other residents' rooms. The note continued with Resident #37 began swinging his cane in the hallway towards the resident in one of the rooms. Resident #37 was informed he could not use his cane to hit another person or swing it toward anyone in the facility. Resident #37 then called the nurse a racial slur and began swinging his cane towards the nurse. The nurse was able to get the cane and escorted Resident #37 back to his room. The Assistant Director of Nursing (ADON) was made aware.</p> <p>Nursing note dated 5/28/24 and authored by Nurse #2 started the nurse had spoken with Resident #37's family about his verbal and physical aggression towards staff and resident. A new order was received for Ativan 3 times a day (TID).</p> <p>Patient centered care follow note dated 5/28/24 revealed Resident #37 was seen for an acute visit due to nursing staff complaint of agitation. Resident #37 stated he had been feeling more agitated lately. There were no new recommendations identified on the follow up note.</p> <p>Review of SBAR Summary for providers dated 6/2/24 and authored by Nurse #4 indicated a change in condition that was identified as behavioral symptoms to include agitation and psychosis. The note continued with nursing observations, evaluation and recommendations were Resident #37 was observed being verbally aggressive with staff. Charged staff member resulting in loss of balance and fall without injury. Resident continued verbally aggression shortly after occurrence. The on-call Nurse Practitioner (NP) indicated to send resident to emergency room (ER) for evaluation. The recommendations stated send Resident #37 to ER for evaluation following combative/aggressive behavior.</p> <p>Review of Resident #37's medical record revealed a new application for PASRR had not been completed after the resident was diagnosed with PTSD and demonstrated a change in behaviors.</p> <p>Interview with the Social Worker on 6/13/24 at 11:00 am revealed she was responsible for submitting information to North Carolina Medicaid Uniform Screening Tool (NC MUST-an online platform used to complete PASRR applications) when a resident experienced a change in condition regarding behaviors that may be associated with mental illness. She further indicated she had a number of residents during her audit that were in need of being screened or re-screened. She indicated she was aware of an increase in behaviors with Resident #37 and indicated with his change in condition he would need to be screened to determine if there would be a change in his PASRR I status.</p> <p>In a continued interview with the Social Worker on 6/13/24 at 11:20 am indicated Resident #37 was not identified during her audit and had not had a request for screening by PASRR. She further stated she must have missed him during her audit.</p> <p>(continued on next page)</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with the Director of Nursing (DON) on 6/13/24 at 3:18 pm revealed the Social Worker was responsible for notifying NC MUST of residents that had a change in condition to establish a new PASRR level.</p> <p>27111</p> <p>2. Review of Resident #102's medical record revealed documentation of a Level I PASRR determination dated 6/22/18 prior to his admission on 11/8/21. His admission diagnoses included dysphagia and hypertension.</p> <p>A diagnosis of schizoaffective disorder was added on 11/1/23. Further record review did not indicate a referral for a Level II PASRR review had been made.</p> <p>An interview with the Social Worker on 6/13/24 at 2:01PM revealed that she was not aware of Resident #102 had a change of diagnosis.</p> <p>An interview with the Administrator on 6/14/24 at 10:40 AM revealed a new diagnosis of paranoid schizophrenia or schizoaffective disorder should be triggered for a new PASRR evaluation. She indicated that she had started an audit to make sure that the PASRR was getting done by the Social Worker. She stated maybe the audit was not as effective as she thought since one of the residents was missed by the audit.</p> <p>3. Review of Resident #103's medical record revealed documentation of a Level I PASRR determination dated 7/21/17 prior to his admission on 12/17/21. His admission diagnoses included anxiety, depression, respiratory failure and diabetes mellitus.</p> <p>A diagnosis of paranoid schizophrenia was added on 8/1/23. Further record review did not indicate a referral for a Level II PASRR review had been made.</p> <p>An interview with the Social Worker on 6/13/24 at 2:01PM revealed that Resident #103 had the new diagnosis of paranoid schizophrenia and corporate had directed her to refer for a new PASRR. She revealed that the new diagnosis was on 8/1/23 and it should have already been referred. She indicated that she had the stack of referrals on her desk, she was the only person with the PASRR logon, and she was behind.</p> <p>An interview with the Administrator on 6/14/24 at 10:40 AM revealed a new diagnosis of paranoid schizophrenia or schizoaffective disorder should be triggered for a new PASRR evaluation. She indicated that she had started an audit to make sure that the PASRR was getting done by the Social Worker. She stated maybe the audit was not as effective as she thought since one of the residents was missed by the audit.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38077</p> <p>Based on record review, staff and resident interviews the facility failed to involve the resident and/or resident representative in the care planning process for 1 of 1 sampled resident (Resident #94) reviewed for care plan participation.</p> <p>The findings included:</p> <p>Resident #94 was admitted on [DATE] with diagnoses in part, Diabetes Mellitus, Chronic Obstructive Pulmonary Disease and major depression.</p> <p>Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #94 was assessed as cognitively intact</p> <p>Review of the Social Worker Note dated 2/21/24 and authored by Social Worker Assistant #2 indicated Resident #94 was assessed as alert and oriented to self, place, time and situation. The resident was able to make needs known to staff without issue. Resident #94 was assessed as cognitively intact. The resident would remain in the facility for Long Term Care (LTC) Services. SW will continue to monitor.</p> <p>Review of the resident's care plan (completion date) 3/18/24 revealed the resident was care planned for activities of daily living (ADLs), nutrition, falls, risk for pressure ulcers, discharge planning and other medical conditions.</p> <p>A record review of the Quarterly MDS assessment dated [DATE] revealed Resident #94 was assessed as cognitively intact and was dependent on staff for ADL care.</p> <p>During an interview on 6/10/24 at 10:09 AM, Resident #94 indicated he was not invited to participate in the care plan meeting for the past 4 months. He further indicated he had not recalled participating in developing his plan of care.</p> <p>During an interview on 6/12/24 at 11:00 AM, the Social Worker Assistant #2 stated the resident's base line care plan was completed on the phone with the resident's representative on 2/16/24. The resident's representative was the responsible party and emergency contact #1. The resident was also present and requested his representative for attendance. Resident #94's discharge planning was discussed, and he was a long-term care resident. The Social Worker Assistant #2 stated usually after the base line care plan meeting, a comprehensive care plan meeting was completed in 5 days. During the comprehensive care plan meeting team reviewed the care plan to see if there were any changes. The resident and/or resident representative was invited to participate in the care plan. The Social Worker Assistant #2 further stated that the resident's comprehensive care plan meeting with the resident and/or resident's representative was missed and there was no care plan meeting completed. The Social Worker Assistant #2 stated she was in contact with Resident #94's representative regarding the care plan meeting for the quarterly MDS assessments. The care plan meetings were done face to face or Virtual (over phone or online) based on their preferences and convenience.</p> <p>(continued on next page)</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/12/24 at 11:10 AM, the Social Worker Director stated the resident's admission MDS assessment was completed on 2/21/24. The resident's quarterly assessment was completed on 5/14/24. She indicated the Social Worker Assistant #2 was in the process of scheduling the quarterly assessment care plan meeting with Resident #94's representative. The Social Worker Director stated she goes by the date of MDS assessment and the letters to residents and resident's family members were sent out based on the MDS calendar. The Social Worker Director further stated she usually mailed out the care plan meeting letters. She indicated she had not recollected sending out the letter for comprehensive care plan meeting to the family or the resident. Social Worker Director stated the admission staff scheduled the baseline care plan meeting for the resident and/or representative. She further stated the Social Worker department was responsible for scheduling and conducting the comprehensive and other care conferences.</p> <p>During an interview on 6/12/24 at 4:09 PM, the Administrator stated the expectation was that care plan meetings and notifications were completed per the state/ federal regulations. The Administrator stated the care plan should be reviewed and revised by the interdisciplinary team after each assessment, including comprehensive and quarterly assessments. She further stated residents and/or resident representatives should be involved in the care plan meeting and make decision about their care. The Administrator further stated letters to the families should be sent out by social services for care plan meeting and accommodate the meeting based on families' convenience as much as possible.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38920</p> <p>Based on record review, observation, staff, and resident interviews, the facility failed to provide (1) incontinence care to a resident dependent on staff. The facility also (2) failed to provide nail care to a resident who was dependent on staff. This occurred for 2 of 2 residents (Resident #209 and Resident #14) reviewed for activities of daily living (ADL) care.</p> <p>Findings included:</p> <p>1. Resident #209 was admitted to the facility on [DATE] with multiple diagnoses that included enterocolitis and diabetes.</p> <p>The 5-day Minimum Data Set (MDS) dated [DATE] revealed Resident #209 was cognitively intact and required substantial to max assistance with toileting. The MDS also documented Resident #209 was frequently incontinent of urine and always incontinent of bowel.</p> <p>Resident #209's care plan dated 5-23-24 revealed the resident had an activities of daily living (ADL) deficit due to enterocolitis and diabetes. The goal for Resident #209 was to improve the current level of ADL function. The interventions were one staff assist for personal hygiene and toileting. Resident #209 also had an intervention for two staff to assist the resident with transfers.</p> <p>Resident #209 was interviewed on 6-10-24 at 11:25am. Resident #209 was observed to be tearful and stated she had been laying in a soiled and urine saturated brief since 8:15am. The resident explained she had put her call light on at 8:15am (stated she knew it was 8:15am because she looked at the clock on the wall) and asked NA #8 to be changed. She stated NA #8 told her she had to wait because the breakfast trays were arriving on the unit. Resident #209 said she told NA #8 again when she delivered her tray that she needed changed and stated NA #8 told her she would get changed after breakfast. Resident #209 discussed not receiving incontinence care since the night before. She stated she still had not been changed. There was a strong urine odor observed in Resident #209's room. The resident was observed to put her call light back on for assistance.</p> <p>Observation of incontinence care occurred on 6-10-24 at 11:33am with NA #4. During the observation, Resident #209 was observed to have 3 briefs and another brief was laid flat under her. It was observed that Resident #209's bowel movement and urine had seeped through all 3 briefs, the draw sheet, the cotton pad, and the fitted sheet. There were areas on the draw sheet, cotton pad, and fitted sheet that had dark yellow rings and on Resident #209's skin there were areas where her bowel movement had dried to her skin. The resident's skin was intact with no redness.</p> <p>NA #4 was interviewed on 6-10-24 at 11:44am. The NA explained she had come into work late, so she had not completed initial rounds on her assigned residents. She confirmed Resident #209 was assigned to her. NA #4 stated NA #8 had not informed her when she arrived that Resident #209 needed to be changed. When discussing the condition of Resident #209, NA #4 discussed that it was not normal practice to see 3 briefs on a resident and that due to the drying of urine and dried feces, NA #4 said she did not think the resident had been changed since the night before. NA #4 explained staff could change residents even when trays were being delivered and did not know why Resident #209 had not received incontinence care.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with NA #8 on 6-10-24 at 11:50am, NA #8 explained the NA assigned to Resident #209 had come to work late so initial rounds were not completed on the resident. She stated at 8:15am, Resident #209 had put her call light on but said the resident never informed her she needed to be changed. When asked, NA #8 could not state what activity she provided the resident or what the resident wanted at 8:15am when she answered her call light. She also stated when she provided Resident #209 with her breakfast tray, the resident never told her she needed to be changed.</p> <p>A telephone interview occurred with NA #9 on 6-12-24 at 7:30am. The NA confirmed she had been assigned to Resident #209 on 6-9-24 during the 11:00pm to 7:00am shift. NA #9 explained she had usually changed Resident #209 every hour because she urinates a lot. She stated she had last changed Resident #209 between 6:00am and 6:30am on 6-10-24. NA #9 discussed Resident #209 asked for 2 briefs, but the NA stated she placed one brief on the resident and laid another one down flat under the resident. NA #9 stated she had not placed 3 briefs on the resident.</p> <p>The Director of Nursing was interviewed on 6-12-24 at 2:37pm. The DON discussed staff receiving yearly training on incontinence care. She stated staff were able to provide incontinence care if the meal trays were on the unit but that she would expect them to wash their hands prior to passing the trays. The DON discussed Resident #209 and stated no resident should have to eat their meal in a soiled and wet brief and should have been provided incontinence care when requested. She also stated it was not the facilities policy to apply more than one brief to a resident. The DON explained if the resident requested more than one brief, the resident would be care planned for more than one brief.</p> <p>The Administrator was interviewed on 6-12-24 at 4:32pm. The Administrator discussed it not being appropriate for a resident to have on more than one brief but also said she felt this may have been a one-time occurrence. She stated if Resident #209 urinated frequently, then she would expect the resident to be care planned for more frequent visits. The Administrator stated Resident #209 should have been provided incontinence care when requested and not have to eat her meal in a soiled, wet brief.</p> <p>2. Resident #14 was admitted to the facility on [DATE] with multiple diagnoses that included hemiplegia and hemiparesis affecting non-dominant side.</p> <p>The quarterly Minimum Data Set, dated dated [DATE] revealed Resident #14 was moderately cognitively impaired and was dependent on staff for bathing and personal hygiene. The MDS did not document any rejection of care.</p> <p>Resident #14's care plan dated 5-11-24 revealed an ADL deficiency related to hemiplegia. The goal for Resident #14 was to maintain her current level of function. The interventions for the goal included total staff participation in personal hygiene and bathing.</p> <p>Resident #14 was observed and interviewed on 6-10-24 at 1:12pm. Resident #14 discussed having a bath this morning by staff however during the observation of the resident, her fingernails were observed to have a brown substance caked under her nails, her gown had dried food particles, and her fitted sheet had holes and dried food.</p> <p>Observation and interview with Resident #14 occurred on 6-11-24 at 11:09am. Resident #14 discussed hospice providing her a bath this morning. Upon observation, Resident #14 was observed to have a brown substance caked under her fingernails.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An observation of ADL care with Resident #14 occurred on 6-12-24 at 9:41am with Nursing Assistant (NA) #11. Resident #14's skin was observed to be intact with no redness. NA #11 was observed not to clean Resident #14's fingernails.</p> <p>NA #11 was interviewed on 6-12-24 at 9:57am. NA #11 discussed the steps she took providing a bath to a dependent resident. The NA stated she usually provided nail care to her dependent residents, but she had become nervous and forgot to perform nail care on Resident #14.</p> <p>The Director of Nursing (DON) was interviewed on 6-12-24 at 2:37pm. The DON discussed the training for the NAs regarding bathing and stated nail care was part of the bathing process. She stated between the facility staff and hospice, Resident #14 should not have gone without her nails being cleaned for 2 days.</p> <p>The Administrator was interviewed on 6-12-24 at 4:32pm. The Administrator discussed staff having tunnel vision when they are bathing a resident and forget that nail care was part of a bath. She stated she expected staff to look at the whole resident not just limbs and torso.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31146</p> <p>Based on observation, record review and staff interview the facility failed to have cautionary signage for oxygen (O2) use for 1 of 2 residents (Resident #176) reviewed for respiratory care.</p> <p>The findings included:</p> <p>Resident #176 was admitted to the facility on [DATE] with a diagnosis that included chronic obstructive pulmonary disease (COPD).</p> <p>The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #176 was cognitively intact. She was further coded as receiving oxygen therapy.</p> <p>Review of Resident #176 physician order dated 4/10/24 stated oxygen continuously at 3 liters per minute (lpm) via nasal cannula for COPD.</p> <p>Observation on 6/10/24 at 10:29 am revealed Resident #176 to be in her room with O2 being delivered via nasal cannula. There was no cautionary signage observed to the entrance of Resident #176's room indicating the use of O2.</p> <p>Observation on 6/11/24 at 4:26 pm revealed Resident #176 to be in her room with O2 being delivered via nasal cannula. There was no cautionary signage indicating the use of O2.</p> <p>Interview and observation with Nurse #8 on 6/11/24 at 4:30 pm revealed she was assigned to Resident #176. She stated that Residents that received O2 were to have signage that identified O2 was in use on the outside of the their bedroom door. Upon observation of Resident #176's room door she confirmed it did not have O2 signage. She further stated that she was unsure if it was maintenance department or the Unit Supervisor who would place cautionary signage indicating the use of O2.</p> <p>Interview with Unit Supervisor on 6/12/24 at 11:45 pm revealed there was no cautionary signage on Resident #176's door indicating the use of O2 until she had noticed the signage was missing on 6/12/24. She stated she was told by the Director of Nursing (DON) 6/12/24 to check for cautionary signage for O2 which was when she identified Resident #176's was missing. The Unit supervisor indicated Resident #176 had been recently moved to room [ROOM NUMBER] from 212 about a month ago.</p> <p>Interview with the Director of Nursing (DON) on 6/13/24 at 3:18 pm revealed cautionary signage regarding the use of O2 should be placed on residents' doors that require O2. Resident #176 was on O2 and should have had cautionary signage. It was the responsibility of the admissions nurse or the floor nurse to ensure cautionary signage was posted for residents who utilized O2.</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide medically-related social services to help each resident achieve the highest possible quality of life.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45276</p> <p>Based on record review, resident and staff interviews the facility failed to ensure a resident attended an infectious disease clinic appointment at an outside facility for 1 of 1 sampled resident reviewed for medically related social services (Resident #616).</p> <p>The findings included:</p> <p>Resident #616 was admitted on [DATE] with diagnoses that included pneumonia, diabetes, latent tuberculosis, and chronic kidney disease.</p> <p>Review of Resident #616's hospital discharge summary 02/29/24 revealed an infectious disease clinic appointment scheduled for 03/11/24.</p> <p>Resident #616's admission Minimum Data Set (MDS) assessment dated [DATE] revealed she was cognitively intact.</p> <p>There was no evidence in the medical record that Resident #616 attended her 03/11/24 infectious disease clinic appointment scheduled for 03/11/24 as noted on the hospital discharge summary.</p> <p>The medical record indicated Resident #616 was discharged from the facility on 03/13/24.</p> <p>A phone interview was conducted on 06/10/24 at 10:20 AM with Resident #616 and she stated she was informed the transportation van was not working the morning of 03/11/24 and her appointment would be rescheduled. She stated she was not rescheduled for her infectious disease clinic appointment prior to her discharge to the hospital on 03/13/24.</p> <p>An interview was conducted with the Resident Appointment Coordinator on 06/13/24 at 3:00 PM. She stated Resident #616's appointment was on her transportation schedule for 3/11/24 and she verified the infectious disease clinic appointment was missed. She reported the transportation van wheelchair lift malfunctioned the morning of 03/11/24 and they could not use it to transport residents. She stated the other transportation van was being used to transport dialysis residents that morning. The Resident Appointment Coordinator stated she usually called the same day or next day to reschedule a missed appointment. She explained sometimes she was not able to reschedule within a day or two because she helped escort residents to appointments. The Resident Appointment Coordinator said Resident #616 was not rescheduled for her infectious disease clinic appointment before she was discharged to the hospital on 3/13/24.</p> <p>An interview was conducted with the Administrator on 06/14/24 at 2:00 PM. The Administrator stated the Resident Appointment Coordinator should have rescheduled the appointment in a timely manner.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32394</p> <p>Based on observations, interviews with a representative from the dispensing pharmacy and facility staff, and record reviews, the facility failed to ensure a medication (a topical anti-fungal powder) was available for application as ordered by a physician, resulting in multiple doses of the prescribed medication being missed for 1 of 4 residents (Resident #416) observed during the medication administration observation.</p> <p>The findings included:</p> <p>Resident #416 was discharged from a hospital to the facility on [DATE] with a diagnosis which included cirrhosis of the liver. His hospital Discharge Medication List (dated 5/30/24) indicated Resident #416 should discontinue use of 250 milligram (mg) terbinafine (an oral antifungal medication) previously taken and initiate the use of 2 percent (%) miconazole powder (a topical antifungal medication) to be applied topically two times daily.</p> <p>The resident's admission orders to the facility included a medication order dated 5/30/24 for 2% miconazole powder to be topically applied to folds of the skin twice daily for dry skin (Start Date 5/31/24). The order was created and confirmed by Nurse #3 on 5/30/24. Further review of Resident #416's electronic medical record (EMR) included a 5/30/24 Admitting Daily Skin Assessment which reported the resident had Dry skin to feet . An Admission Data Collection Note (also dated 5/30/24) included a notation which indicated the resident had Bruising to arms and hands, dry skin all over.</p> <p>On 6/12/24 at 9:53 AM, Nurse #3 was observed as she prepared and administered five oral medications to Resident #416. At that time, the nurse reported she knew this resident's miconazole powder was not available on the medication (med) cart for administration because it had not yet been delivered by the pharmacy. A follow-up interview was conducted on 6/12/24 at 10:10 AM with Nurse #3. During the interview, the nurse further explained that since she could not apply the miconazole powder as ordered for Resident #416, she made notations on the resident's Medication Administration Record (MAR) to indicate the medication was not available.</p> <p>A review of Resident #416's May 2024 and June 2024 MARs revealed the resident's miconazole was scheduled to be applied at 9:00 AM and 9:00 PM each day in accordance with the physician's orders. However, the MARs also documented the miconazole was not applied as ordered on 20 occasions between 5/31/24 and 6/12/24.</p> <p>The resident's EMR and pharmacy orders were reviewed on 6/12/24 at 10:48 AM. At that time, the physician's order for 2% miconazole topical powder was listed as an Active order for Resident #416 and its status was reported as On Order.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on 6/12/24 at 4:05 AM with the facility's Central Supply clerk. During the interview, the Central Supply clerk reported she was not aware that an over the counter antifungal powder was ordered for Resident #416 until that morning (6/12/24) when the Unit Manager (Nurse #2) came to the Central Supply to request it. The Central Supply clerk confirmed the medication requested was an over the counter (OTC) medication and reported she had a similar antifungal powder in stock that may be used as an alternative (with a physician's order). An inquiry was made as to what the facility's process was for an OTC medication to be sent up to the floor. In response, the Central Supply clerk stated as soon as the order was received for an OTC medication, the nursing staff was supposed to notify her so she could have it brought up to the floor. If that medication was not in the Central Supply stock, the clerk stated she would attempt to acquire it from a local retail pharmacy. However, the clerk reiterated that she relied on the nursing staff to notify her of the need for an OTC medication so she could be certain the product was available for the resident.</p> <p>A telephone interview was conducted on 6/14/24 at 10:10 AM with a representative from the facility's contracted dispensing pharmacy. During the interview, the representative reported, All facilities know we do not provide OTC medications. The representative added that normally the facilities knew what they had in stock and stated, They should know what is OTC. She reported the dispensing pharmacy would not call a facility to remind them that an OTC medication was not going to be provided by the pharmacy. However, the representative added, We would document if there had been an inquiry by the facility about whether a medication would be sent out by the pharmacy. Upon request, the representative checked to see if the facility had made an inquiry about Resident #416's miconazole not being delivered since it was ordered on 5/30/24. She stated there was no documentation of an inquiry being made by the facility.</p> <p>An interview was conducted on 6/13/24 at 4:01 PM with the facility's Director of Nursing (DON) and Administrator to discuss the results of the medication administration observation. At that time, the DON and Administrator were also informed of the facility's failure to obtain an OTC antifungal product ordered by the physician for a newly admitted resident (Resident #416). A follow-up interview was conducted on 6/14/24 at 12:55 PM with the DON. During the interview, the DON stated she would expect nursing staff to call the dispensing pharmacy if a medication ordered was not received so if that medication was an OTC product, the facility could acquire it on their own.</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32394</p> <p>Based on staff and consultant pharmacist interviews and record reviews, the facility failed to act on recommendations made by the consultant pharmacist and retain documentation of the physician's review and response to the pharmacist's findings / recommendations in the resident's medical record for 1 of 7 residents whose medications were reviewed (Resident #97).</p> <p>The findings included:</p> <p>Resident #97 was admitted to the facility on [DATE]. Her cumulative diagnoses included an adjustment disorder with anxiety.</p> <p>A review of the resident's electronic medical record (EMR) revealed the following medication orders were received for diazepam (an antianxiety medication). Diazepam is a psychotropic medication and a controlled substance medication.</p> <p>--A physician's order was received on 11/10/23 for 5 milligram (mg) diazepam to be given as one tablet by mouth every 8 hours as needed (PRN) for anxiety. The order was discontinued on 12/6/23.</p> <p>--On 12/12/23, 5 mg diazepam was ordered to be given by mouth every 8 hours PRN for anxiety and/or muscle relaxant. This order was discontinued on 12/19/23.</p> <p>--A physician's order was received on 12/19/23 for 5 milligram (mg) diazepam (an antianxiety medication) to be given as one-half tablet (2.5 mg) by mouth scheduled twice daily for anxiety.</p> <p>--On 2/23/24, an order was received for 10 mg diazepam to be given as one tablet by mouth every 8 hours as needed for crying and/or anxiety. There was no end date or rationale documented for this PRN diazepam order to be extended beyond 14 days.</p> <p>--The order for the 2.5 mg of scheduled diazepam given twice daily was discontinued on 3/22/24 and another order was received on 3/22/24 for 5 mg of diazepam to be given as one tablet by mouth scheduled twice a day for anxiety.</p> <p>The resident's most recent Minimum Data Set (MDS) was a quarterly assessment dated [DATE]. Resident #97 was reported to have intact cognition with no behaviors nor rejection of care. The Medication section of the MDS revealed Resident #97 received an antianxiety medication during the 7-day look back period.</p> <p>Resident #97's EMR indicated the physician's orders for both the scheduled diazepam (ordered on 3/22/24) and the PRN diazepam (ordered on 2/23/24) continued as active orders up through the date of the review on 6/12/24. A review of Resident #97's Medication Administration Records (MARs) revealed eight (8) doses of PRN diazepam were administered to the resident from 2/23/24 through the date of the review (6/12/24). The last dose of PRN diazepam was documented as having been administered on 6/7/24.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The resident's EMR also included Pharmacist Reviews / Visit Progress Notes completed by the consultant pharmacist each month from August 2023 to May 2024 on the following dates: 8/31/23; 9/30/23 10/30/23; 11/29/23; 12/30/23; 1/30/24; 2/29/24; 3/30/24; 4/30/24; and 5/31/24. Each of these monthly notes read: MRR [Medication Regimen Review] completed: Medical Record Reviewed including: orders, available labs, progress notes. See consultant pharmacist report for consult on any noted irregularities and/or recommendations.</p> <p>A request was made for the facility to provide the consultant pharmacist reports with the noted irregularities and/or recommendations made for Resident #97 from August 2023 up to the date of the review (6/12/24). The facility provided two pharmacist reports (Consultant Pharmacist Medication Regimen Reviews) for Resident #97. Only one report (dated 2/29/24) was related to the PRN diazepam ordered for Resident #97. The Consultant Pharmacist Medication Regimen Review dated 2/29/24 noted the pharmacist made a recommendation to Psychiatry which read, PRN psychotropic orders are limited to 14 days unless the prescriber deems it appropriate to extend the order. If elect to continue, please document a clinical rationale and a duration for the PRN order. This recommendation was signed by a Nurse Practitioner (NP) on 3/21/24 with a response that read: Continue current dose of diazepam 10 mg q 8 hrs (every eight hours) PRN for anxiety. Neither the duration of the order nor the clinical rationale for continuation of the PRN diazepam were addressed in the provider's response.</p> <p>The NP who responded to the pharmacist's 2/29/24 recommendation related to PRN diazepam use for Resident #97 was not available for an interview and no longer worked at the facility.</p> <p>A telephone interview was conducted on 6/13/24 at 3:23 PM with the facility's consultant pharmacist. During the interview, the pharmacist confirmed she had made multiple recommendations to address the use of Resident #97's PRN diazepam over the last several months. The pharmacist was also informed of a concern regarding the facility's failure to retain the pharmacist's Consult Reports and/or provider responses. She stated that all the pharmacist's recommendations (without the physician's responses) were available for review within the facility via a connection with the pharmacy's software. The pharmacist reported she typically encouraged each of her facilities to give one copy of the pharmacy recommendations to the provider while they kept a second copy in a binder. After the provider returned a signed response for the recommendation, one copy should be scanned into the resident's permanent medical record with another copy replacing the unsigned recommendation in the binder.</p> <p>On 6/14/24 at 9:14 AM, additional documentation was provided by the consultant pharmacist for review. The documents included three (3) Consultant Pharmacist Medication Regimen Reviews with recommendations related to Resident #97's PRN diazepam. These three Consultant Pharmacist Medication Regimen Reviews had not been previously provided by the facility. Neither the resident's EMR nor the facility provided documentation to show Resident #97's physician reviewed or responded to the following Consultant Pharmacist Medication Regimen Reviews:</p> <p>--On 11/30/23, the pharmacist made a physician recommendation which noted, PRN psychotropic orders are limited to 14 days unless the prescriber deems it appropriate to extend the order. If elect to continue, please document a clinical rationale and a duration for the PRN order.</p> <p>--On 1/31/24, a recommendation was made to Psychiatry which read, PRN psychotropic orders are limited to 14 days unless the prescriber deems it appropriate to extend the order. If elect to continue, please document a clinical rationale and a duration for the PRN order.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>--On 5/31/24, a recommendation was again made to Psychiatry which read, PRN psychotropic orders are limited to 14 days unless the prescriber deems it appropriate to extend the order. If elect to continue, please document a clinical rationale and a duration for the PRN order.</p> <p>An interview was conducted on 6/14/24 at 12:50 PM with the facility's Director of Nursing (DON). During the interview, the DON reported she was aware that orders for PRN psychotropic medications required a stop date. The DON also stated that she was now aware that additional documentation was required to continue PRN psychotropic medications (other than antipsychotic meds) for an extended duration.</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32394</p> <p>Based on staff and consultant pharmacist interviews and record reviews, the facility failed to limit the duration of psychotropic medications (any drug that affects brain activities associated with mental processes and behavior) ordered on an as needed (PRN) basis to 14 days and/or indicate the duration and rationale for the PRN order to be extended beyond 14 days, when appropriate. This occurred for 2 of 7 residents whose medications were reviewed (Resident #97 and Resident #28).</p> <p>The findings included:</p> <p>1. Resident #97 was admitted to the facility on [DATE]. Her cumulative diagnoses included chronic obstructive pulmonary disease (COPD) and adjustment disorder with anxiety.</p> <p>A review of the resident's electronic medical record (EMR) revealed the following medication orders were received for diazepam (an antianxiety medication). Diazepam is a psychotropic medication and a controlled substance medication.</p> <p>--A physician's order was received on 11/10/23 for 5 milligram (mg) diazepam to be given as one tablet by mouth every 8 hours as needed (PRN) for anxiety. The order was discontinued on 12/6/23.</p> <p>--On 12/12/23, 5 mg diazepam was ordered to be given by mouth every 8 hours PRN for anxiety and/or muscle relaxant. This order was discontinued on 12/19/23.</p> <p>--A physician's order was received on 12/19/23 for 5 milligram (mg) diazepam (an antianxiety medication) to be given as one-half tablet (2.5 mg) by mouth scheduled twice daily for anxiety.</p> <p>--On 2/23/24, an order was received for 10 mg diazepam to be given as one tablet by mouth every 8 hours as needed for crying and/or anxiety. There was no end date or rationale documented for this PRN diazepam order to be extended beyond 14 days.</p> <p>--The order for the 2.5 mg of scheduled diazepam given twice daily was discontinued on 3/22/24 and another order was received on 3/22/24 for 5 mg of diazepam to be given as one tablet by mouth scheduled twice a day for anxiety.</p> <p>The resident's most recent Minimum Data Set (MDS) was a quarterly assessment dated [DATE]. Resident #97 was reported to have intact cognition with no behaviors nor rejection of care. The Medication section of the MDS revealed Resident #97 received an antianxiety medication during the 7-day look back period.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Willow Valley Center for Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 1900 W 1st Street Winston-Salem, NC 27104	
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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #97's EMR indicated the physician's orders for both the scheduled diazepam (ordered on 3/22/24) and the PRN diazepam (ordered on 2/23/24) continued as active orders up through the date of the review on 6/12/24. A review of Resident #97's Medication Administration Records (MARs) revealed eight (8) doses of PRN diazepam were administered to the resident from 2/23/24 through the date of the review (6/12/24). The last dose of PRN diazepam was documented as having been administered on 6/7/24.</p> <p>A telephone interview was conducted on 6/13/24 at 3:23 PM with the facility's consultant pharmacist. During the interview, the pharmacist reported she had made multiple recommendations to address the use of Resident #97's PRN diazepam on each of the following dates: 11/30/23, 1/31/24, 2/29/24, and 5/31/24. Each recommendation read, in part, PRN psychotropic orders are limited to 14 days unless the prescriber deems it appropriate to extend the order. If elect to continue, please document a clinical rationale and a duration for the PRN order.</p> <p>An interview was conducted on 6/14/24 at 12:50 PM with the facility's Director of Nursing (DON). During the interview, the DON reported she was aware that orders for PRN psychotropic medications required a stop date. The DON also stated that she was now aware that additional documentation was required to continue PRN psychotropic medications (other than antipsychotic meds) for an extended duration.</p> <p>42007</p> <p>2. Resident #28 was admitted to the facility on [DATE] with diagnoses including dementia, repeated falls, major depressive disorder, and chronic diastolic heart failure.</p> <p>The resident's most recent Minimum Data Set (MDS) was a quarterly assessment dated [DATE]. Resident #28 was severely cognitively impaired and there were no behavior concerns during the 7-day look back period. The medication section showed that she received an antipsychotic medication (type of psychotropic medication).</p> <p>A review of Resident #28's electronic medical record (EMR) revealed a physician's order dated 5/8/24 for Haloperidol oral tablet 2 mg, give 1 tablet every 6 hours as needed for agitation. Haloperidol is a psychotropic medication. There was no end date documented for this medication. The Nurse Practitioner wrote this order.</p> <p>A review of Resident #28's May and June 2024 medication administration records revealed she had received a dose of Haloperidol 2 mg on 5/9, 5/11, 5/13, 5/15, 5/16, 5/19 (3doses), 5/20, 5/21, 5/22, 5/24, 5/30, 6/1, 6/5, 6/8, and 6/12.</p> <p>During an interview with Nurse #4 on 6/13/24 at 2:25 pm, he stated that he entered Resident #28's order for Haloperidol into the system and was unaware that prn psychotropics had to have a 14 day stop date.</p> <p>During an interview with the Nurse Practitioner on 6/14/24 at 1:25 pm, she confirmed she wrote the Haloperidol order dated 5/8/24 without the 14-day stop date and stated that she was aware that all prn psychotropics had a 14 day stop date and that was how she intended the order to be entered.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/14/24 at 3:34 PM with the Director of Nursing (DON), she stated she was aware that orders for PRN psychotropic medications required a stop date. She stated that the Nurse Practitioner came in that morning and noticed there was no stop date for Resident # 28's PRN Haloperidol. The Nurse Practitioner discontinued the current order and placed a new order with a 14-day stop date.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32394</p> <p>Based on observations, staff interviews, and record reviews, the facility failed to have a medication error rate of less than 5% as evidenced by 2 medication errors out of 29 opportunities, resulting in a medication error rate of 6.9% for 2 of 4 residents (Resident #74 and Resident #416) observed during the medication administration observation.</p> <p>The findings included:</p> <ol style="list-style-type: none"> Resident #74 was admitted to the facility on [DATE]. Her cumulative diagnoses included hypertension and a history of cerebrovascular accident (stroke) with dysphagia (difficulty swallowing). <p>On 6/12/24 at 8:28 AM, Nurse #4 was observed as he prepared to administer medications to Resident #74. The nurse collected blood glucose (sugar) monitoring supplies, checked Resident #74's blood glucose, and administered 4 units of Humalog insulin (a rapid-acting insulin) to the resident in accordance with her physician's orders.</p> <p>At 8:39 AM on 6/12/24, Nurse #4 was observed as he completed his preparation of five (5) medications for administration via a percutaneous endoscopic gastrostomy (PEG tube) to Resident #74. A PEG tube is a feeding tube surgically inserted into the stomach. The medications administered to the resident included one tablet of 25 milligrams (mg) carvedilol (a blood pressure medication). Each medication was observed to be crushed individually, mixed with water, and administered separately into the PEG tube with 5-10 milliliters (ml) of water instilled between each medication. No vital signs were obtained for Resident #74 prior to the medication administration.</p> <p>On 6/12/24 at 8:56 AM, Nurse #4 completed the medication administration for Resident #74 and returned to the medication cart. A review of the resident's current medication orders was completed at that time. The orders included 25 mg carvedilol to be given as one tablet via PEG tube two times a day for hypertension. In capital letters, the order also included parameters which read: Hold for SBP [systolic blood pressure] less than 110 or HR [heart rate] less than 55. Systolic blood pressure is the maximum pressure the heart exerts while beating and is represented by the top number of a blood pressure reading.</p> <p>An interview was conducted on 6/12/24 at 8:58 AM with Nurse #4. During the interview, the nurse was asked when the resident had her vital signs last checked. Nurse #4 reviewed Resident #74's electronic medical record and reported her blood pressure and heart rate were last checked on 6/11/24 (yesterday) at 11:37 AM. The nurse acknowledged he did not notice the resident's orders indicated her vital signs needed to be taken prior to administering the carvedilol.</p> <p>(continued on next page)</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on 6/13/24 at 4:01 PM with the facility's Director of Nursing (DON) and Administrator to discuss the results of the medication administration observation. During the interview, the DON stated she needed to review physician orders with parameters attached to them so supplemental documentation could be added to the Medication Administration Record (MAR) when parameters were indicated for a resident. She explained that adding the supplemental documentation on the MAR would trigger obtaining vital signs so the parameters ordered would be observed prior to a medication's administration. A follow-up interview was conducted on 6/14/24 at 12:55 PM with the DON. At that time, the DON reported she would expect vital sign parameters to be observed and obtained in accordance with the physician orders (if written) prior to administering a medication.</p> <p>2. Resident #416 was admitted to the facility on [DATE] with a diagnosis which included cirrhosis of the liver.</p> <p>On 6/12/24 at 9:53 AM, Nurse #3 was observed as she prepared and administered five (5) oral medications to Resident #416. At that time, the nurse reported this resident's miconazole powder (a topical antifungal powder) was not available on the medication (med) cart for administration because it had not yet been delivered by the pharmacy.</p> <p>A review of Resident #416's current orders revealed a medication order was received on 5/30/24 for 2% miconazole powder to be topically applied to folds of the skin twice daily for dry skin (Start Date 5/31/24). This order was created and confirmed by Nurse #3 on 5/30/24. The miconazole powder was scheduled to be applied at 9:00 AM and 9:00 PM each day in accordance with the physician's orders.</p> <p>A follow-up interview was conducted on 6/12/24 at 3:00 PM with Nurse #3 in the presence of the Unit Manager (Nurse #2). During the interview, the omission of a medication (such as miconazole powder) ordered for administration (or application) was discussed. The nurses reported they understood that because miconazole powder was ordered but not given during the medication administration observation, the omission was determined to be a medication error.</p> <p>An interview was conducted on 6/13/24 at 4:01 PM with the facility's Director of Nursing (DON) and Administrator to discuss the results of the medication administration observation. At that time, the DON and Administrator were informed of the facility's failure to obtain 2% miconazole powder (an over the counter or OTC medication) ordered by the physician for a newly admitted resident (Resident #416). A follow-up interview was conducted on 6/14/24 at 12:55 PM with the DON. During the interview, the DON stated she would expect nursing staff to call the dispensing pharmacy if a medication ordered was not received. She reported that if the medication was an OTC product, the facility would need to acquire it on their own.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>32394</p> <p>Based on observations, interviews with staff, and record reviews, the facility failed to: 1) Label medications (meds) with the minimum information required, including the name of the resident, on 1 of 5 medication (med) carts observed (300 Short Med Cart); 2) Discard expired medications and/or meds without a legible expiration date on 4 of 5 medication carts observed (300 Short Med Cart, 300 Long Med Cart, 200 Long Med Cart, and 200 Short Med Cart); 3) Discard opened single-dose vials (SDV) after their initial use on 2 of 5 medication carts observed (300 Short Med Cart and 300 Long Med Cart); 4) Store medications in accordance with the manufacturer's storage instructions on 2 of 5 medication carts observed (300 Long Med Cart and 200 Long Med Cart).</p> <p>The findings included:</p> <p>1. An observation was conducted on 6/11/24 at 4:00 PM of the 300 Short Med Cart in the presence of Nurse #9.</p> <p>The observation revealed the following medications were stored on the med cart:</p> <p>a. According to the manufacturer, in-use insulin glargine prefilled pens should be stored at room temperature of less than 86 Fahrenheit (oF) and used within 28 days.</p> <p>One (1) opened insulin glargine pen was observed to be stored on the medication cart. The pen was not labeled with a resident's name or the date it had been opened. When asked, Nurse #9 examined the insulin pen and confirmed it was not labeled with a resident's name or date it was opened. The nurse stated the pen would need to be discarded.</p> <p>b. According to the product manufacturer, in-use insulin lispro prefilled pens should be stored at room temperature of less than 86 oF and used within 28 days.</p> <p>One (1) opened insulin lispro prefilled pen was observed to have an illegible name written in a blue marker on the pen. Initially, Nurse #9 stated she thought the insulin pen belonged to Resident #84. However, the pen was stored inside a plastic bag labeled with Resident #103's name. The pen was not labeled as to when it had been opened or put on the medication cart. Upon further inquiry, the nurse stated the pen would need to be discarded.</p> <p>c. According to the product manufacturer, in-use insulin aspart prefilled pens should be stored under refrigeration between 36 oF and 46 oF or at room temperature (less than 86 oF) and used within 28 days.</p> <p>One (1) opened insulin aspart prefilled pen with Resident #185's name hand-written on the pen was stored on the med cart. The pen was also labeled with a handwritten (but illegible) date as to when it had been opened. An interview was conducted with Nurse #9 at the time of the observation. When the nurse was asked whether she could read the date the pen had been opened, she reported she could not.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>d. The Center for Disease Control and Prevention (CDC) Injection Safety Guidelines include information on when single-dose vials (SDVs) should be discarded. The Guidelines state, Vials that are labeled as single-dose or single-use should be used for only a single patient as part of a single case, procedure, injection . Even if a single-dose or single-use vial appears to contain multiple doses or contains more medication than is needed for a single patient, that vial should not be used for more than one patient nor stored for future use on the same patient.</p> <p>One (1) opened 1 milliliter (ml) vial of 1000 micrograms (mcg) / ml of cyanocobalamin (Vitamin B12) for injection was observed stored on the med cart. The vial was labeled as a single dose vial (SDV). At the time of the observation, Nurse #9 was asked what her thoughts were about the opened SDV being stored on the med cart. The nurse responded by stating she would typically discard a SDV after it had been opened.</p> <p>An interview was conducted on 6/13/24 at 4:01 PM with the facility's Director of Nursing (DON) and Administrator to discuss the findings of the Medication Storage and Labeling facility task. Upon inquiry, the DON stated her expectation was for nursing staff to ensure a medication was on the cart at the time of its scheduled administration and to be sure the medication was not expired. With regards to the medications concerns discussed, the DON reported the nursing staff required education on the appropriate storage of medications.</p> <p>2. An observation was conducted on 6/11/24 at 11:38 AM of the 300 Long Medication (Med) Cart in the presence of Nurse #5. The observation revealed the following medications were stored on the med cart:</p> <p>a. According to the product manufacturer, in-use insulin lispro prefilled pens should be stored at room temperature of less than 86 degrees Fahrenheit (oF) and used within 28 days.</p> <p>An opened insulin lispro pen dispensed for Resident #1 was stored on the medication cart. An illegible date was written on a yellow auxiliary sticker placed on the pen to indicate when the pen was opened. No expiration date was noted on the sticker. The yellow auxiliary sticker read, Discard after 28 days. The mini sticker on the pen included a date as to when the pen was dispensed from the pharmacy, but that date was also illegible. At the time of the observation, Nurse #5 was asked what her thoughts were about the dates on the insulin pen. The nurse stated she could not read them.</p> <p>b. According to the product manufacturer, in-use insulin aspart prefilled pens should be stored under refrigeration between 36 oF and 46 oF or at room temperature (less than 86 oF) and used within 28 days.</p> <p>One (1) opened insulin aspart pen dispensed for Resident #209 on 5/13/24 was stored on the med cart. The yellow auxiliary sticker placed on the pen by the pharmacy had two blanks (one blank was for the Date Opened and one for the Date Expired). Neither date was filled out. The auxiliary sticker read, Discard after 28 days. Upon review, it was determined 29 days had elapsed since the insulin pen had been dispensed from the pharmacy.</p> <p>c. According to the manufacturer, in-use insulin glargine prefilled pens should be stored at room temperature (less than 86 oF) and used within 28 days.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>One (1) opened insulin glargine pen dispensed from the pharmacy on 5/9/24 for Resident #190 was stored on the med cart. A yellow pharmacy auxiliary sticker placed on the pen had one date written on the Date Expired line which read, 6/9. Upon inquiry, Nurse #5 stated that most staff usually wrote the opened date on the insulin pens. However, she added that they probably should also write the shortened expiration date on the auxiliary sticker so there would be no confusion. The nurse confirmed it could not be determined for certain whether the insulin pen was past its expiration date.</p> <p>d. The Center for Disease Control and Prevention (CDC) Injection Safety Guidelines include information on when single-dose vials (SDVs) should be discarded. The Guidelines state, Vials that are labeled as single-dose or single-use should be used for only a single patient as part of a single case, procedure, injection . Even if a single-dose or single-use vial appears to contain multiple doses or contains more medication than is needed for a single patient, that vial should not be used for more than one patient nor stored for future use on the same patient.</p> <p>1) Two (2) opened 10 milliliter (ml) single-dose vials (SDV) of sterile water for injection was stored on the med cart. The vial of sterile water for injection was labeled for single use only.</p> <p>2) One (1) opened 5 ml SDV of 1% lidocaine for injection was stored on the med cart. The vial of lidocaine was labeled for single use only.</p> <p>At the time of the observation, Nurse #5 was asked what her thoughts were about the opened SDV being stored on the med cart. The nurse reported the vials needed to be discarded.</p> <p>e. According to the product manufacturer, an unopened Humalog KwikPen should be stored under refrigeration between 36 oF and 46 oF until the expiration date or at room temperature (less than 86 oF) and used within 28 days.</p> <p>One (1) unopened Humalog Kwikpen dispensed from the pharmacy on 6/10/24 for Resident #159 was stored on the med cart. No date was written on the pen as to when it had been put on the med cart. When Nurse #5 was asked, she reported the unopened pen should have been stored in the med room refrigerator until it needed to be opened.</p> <p>An interview was conducted on 6/13/24 at 4:01 PM with the facility's Director of Nursing (DON) and Administrator to discuss the findings of the Medication Storage and Labeling facility task. Upon inquiry, the DON stated her expectation was for nursing staff to ensure a medication was on the cart at the time of its scheduled administration and to be sure the medication was not expired With regards to the medications concerns discussed, the DON reported the nursing staff required education on the appropriate storage of medications.</p> <p>3. An observation was conducted on 6/11/24 at 3:30 PM of the 200 Long Med Cart in the presence of Nurse #6.</p> <p>The observation revealed the following medications were stored on the med cart:</p> <p>a. The manufacturer's storage instructions printed on the box of 0.5 milligrams (mg) / 2 milliliters (ml) budesonide inhalation suspension read, in part: .Store unopened ampules in the foil envelope placed upright in the carton .Once the foil envelope is opened, use the ampules within two weeks.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>1) One (1) manufacturer's box of 0.5 mg/ 2 ml budesonide inhalation suspension ampules dispensed from the pharmacy on 4/23/24 for Resident #415 was stored on the med cart. The box contained one opened envelope with 4 ampules stored inside. The opened envelope was not dated as to when it was opened.</p> <p>2) One (1) manufacturer's box of 0.5 mg/ 2 ml budesonide inhalation suspension ampules dispensed on 4/30/24 for Resident #197 was stored on the med cart. The box contained one opened envelope with 2 ampules stored inside and one ampule placed outside of the foil envelope and lying on the bottom of the box. The opened envelope was not dated as to when it was opened.</p> <p>3) One (1) manufacturer's box of 0.5 mg/ 2 ml budesonide inhalation suspension ampules dispensed on 5/11/24 for Resident #150 was stored on the med cart. The box contained 3 unopened pouches and one opened pouch with 1 ampule stored inside. The opened pouch was not dated as to when it was opened.</p> <p>b. The manufacturer's storage instructions printed on the box of 0.25 mg / 2 ml budesonide inhalation suspension read, in part: .Store unopened ampules in the foil envelope placed upright in the carton .Once the foil envelope is opened, use the ampules within two weeks.</p> <p>One (1) manufacturer's box of 0.25 mg/ 2 ml budesonide inhalation suspension ampules dispensed from the pharmacy on 4/23/24 for Resident #415 was stored on the med cart. The box contained three unopened envelopes and one opened envelope with 1 ampule stored inside. The opened envelope was not dated as to when it was opened.</p> <p>c. The manufacturer's storage instructions printed on the box of 0.5 mg / 3 mg ipratropium / albuterol inhalation solution read in capital letters: Store in pouch until time of use.</p> <p>One (1) manufacturer's box of 0.5 mg / 3 mg ipratropium / albuterol inhalation solution dispensed from the pharmacy on 4/25/24 for Resident #143 was stored on the med cart. Two vials were stored in the manufacturer's box (not inside of a pouch). No pouch was in the box.</p> <p>An interview was conducted with Nurse #6 at the time of the medication cart observation. During the interview, the nurse acknowledged the envelopes (or pouches) containing inhalation solution or suspension ampules needed to be dated when opened.</p> <p>An interview was conducted on 6/13/24 at 4:01 PM with the facility's Director of Nursing (DON) and Administrator to discuss the findings of the Medication Storage and Labeling facility task. Upon inquiry, the DON stated her expectation was for nursing staff to ensure a medication was on the cart at the time of its scheduled administration and to be sure the medication was not expired With regards to the medications concerns discussed, the DON reported the nursing staff required education on the appropriate storage of medications.</p> <p>4. An observation was conducted on 6/11/24 at 3:05 PM of the 200 Short Med Cart in the presence of Nurse #8. The observation revealed the following medications were stored on the med cart:</p> <p>a. According to the manufacturer, in-use Fiasp insulin prefilled pens should be stored under refrigeration between 36 oF and 46 oF or at room temperature (less than 86 oF) and used within 28 days.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>One (1) opened Fiasp insulin pen dispensed from the pharmacy on 4/29/24 for Resident #78 was dated to indicate it was opened on 5/5/24. Upon review, it was determined 37 days had elapsed since the insulin pen had been opened and it was kept past its shortened expiration date. During an interview conducted with Nurse #8, the nurse was asked what her thoughts were with regards to this insulin pen. She confirmed the insulin pen was expired.</p> <p>b. According to the manufacturer, in-use Lantus insulin vials should be stored under refrigeration between 36 oF and 46 oF or at room temperature (less than 86 oF) and used within 28 days.</p> <p>One (1) opened Lantus insulin vial dispensed from the pharmacy on 4/18/24 for Resident #177 was stored on the med cart. A yellow pharmacy auxiliary sticker placed on the vial containing the insulin had two blanks (one blank for the Date Opened and one for the Date Expired). Neither of the dates were filled out. The auxiliary sticker also read, Discard after 28 days. When Nurse #8 was asked how she would know whether the insulin vial had been kept past its shortened expiration date, she stated, I wouldn't.</p> <p>An interview was conducted on 6/13/24 at 4:01 PM with the facility's Director of Nursing (DON) and Administrator to discuss the findings of the Medication Storage and Labeling facility task. Upon inquiry, the DON stated her expectation was for nursing staff to ensure a medication was on the cart at the time of its scheduled administration and to be sure the medication was not expired With regards to the medications concerns discussed, the DON reported the nursing staff required education on the appropriate storage of medications.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345092	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2024
NAME OF PROVIDER OR SUPPLIER Willow Valley Center for Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 1900 W 1st Street Winston-Salem, NC 27104	

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>20670</p> <p>Based on a meal test tray observation and interviews with the Dietary Manager (DM), the facility failed to serve food that was palatable and at temperatures acceptable to 1 of 5 Halls (200 Hall). This practice had the potential to affect other residents.</p> <p>Findings included:</p> <p>An observation of the meal tray line service in the kitchen was conducted on 6/12/24 at 1:15 p.m. The temperatures of the food items on the steamtable were taken by the DM using a calibrated stem thermometer. The temperatures of the food items of regular consistency were greater than the acceptable 135 degrees Fahrenheit. The top of the plated meals was protected with lid covers, but no insulated bottoms due to the large plate size. The meals were placed in a stainless-steel meal delivery cart. The delivery cart was filled with plated meals for the residents on the 200 hall was missing the doors. The cart left the kitchen at 1:23 p.m. and arrived on the 200 long hall at 1:25 p.m. where the nursing staff immediately began serving the residents. A test meal tray of the regular textured foods was included in the meal delivery cart.</p> <p>6/12/24 at 2:05 p.m., the DM revealed that the doors to 4 of the 10 meal delivery carts have needed repair for approximately three months. She also revealed there were not enough insulated bottom plate covers to fit the large plates used for the residents' meals. She stated smaller plates were ordered several months ago but had not been delivered. The DM indicated she had not conducted any meal test trays surveys.</p> <p>On 6/12/24 at 2:32 p.m., after serving the residents of the 200 short halls, the DM and this Surveyor observed the test meal tray for palatability. The shepherd's pie was lukewarm and bland to taste. The greenbeans with corn was lukewarm to taste, flavorless and not thoroughly cooked. The DM participated in the testing of the meal tray and acknowledged these findings.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>20670</p> <p>Based on observations, record reviews, and staff interviews, the facility failed to ensure the sanitizing solution (chlorine) was maintained at the required concentration of 50 ppm (parts per million) during the final rinse cycle according to manufacturer's instructions in the low temperature dish machine; failed to maintain the food service equipment clean, free from debris and in good working condition; failed to ensure leftover food items stored for use in the walk-in cooler and walk-in freezer were sealed, dated and labeled; and failed to ensure facial hair was covered by dietary staff during food preparation. These practices had the potential for cross-contamination of food served to residents.</p> <p>Findings included:</p> <p>1a. During the initial tour of the kitchen on 6/10/24 at 10:40 a.m., the operation of the low temperature dishwasher of the soiled breakfast dishware by dietary staff was observed. The sanitizing solution (chlorine) for the low temperature dishwasher did not register on the chlorine testing strips provided by the dietary staff. After retesting the concentration of the chlorine solution in the dishwasher with the same results, this surveyor informed the DM (Dietary Manager) the observed dishware would have to be rewashed and sanitized: 1-rack of plates, 3-racks of lid covers, 2-racks of meal trays, and 1-rack of silverware.</p> <p>During an interview on 6/10/24 at 10:45 a.m., the DM revealed that earlier that morning she tested the chlorine sanitizer in the dishwasher, and it read 50 ppm. The DM directed the 2-dietary staff to discontinue using the dishwasher and transfer the dishware to the three compartment sink to be rewashed and sanitized.</p> <p>1b. During an observation of the kitchen on 6/12/24 at 1:15 p.m., there were no doors attached to the door hinges of 4 of the 10 meal delivery carts.</p> <p>On 6/12/24 at 2:05 p.m., the DM revealed the doors to 4 of the 10 meal delivery carts had been in disrepair for approximately three months.</p> <p>2a. On 6/10/24 at 10:46 a.m., during the initial tour, the floor of the kitchen had food particles scattered throughout and the floor area near the stove was slippery with grease. The lower wall behind the stove and convection ovens was also littered with dark grease spots. There was black grease and dried food crumbs on the inside and outside of the two convection ovens and the deep fryer. The inside of the two plate-warmers contained food debris and bread slices. Also, next to a food preparation table a stand-alone fan with dry, gray lint covering the protective grid while in use.</p> <p>2b. A follow up visit to the kitchen on 6/12/24 at 2:05 p.m. revealed the lint covered standing fan was in operation while directed at the preparation table where dietary staff was preparing sandwiches. The two plate-warmers contained food debris and plastic gloves in the bottom and clean plates. The filter on the outside of the ice machine contained thick gray lint.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 6/12/24 at 4:56 p.m., the DM stated dietary did not have a cleaning policy but had a sanitation inspection policy checklist. The checklist the DM presented for review did not document the dietary staff assigned to any of the cleaning tasks. She revealed the dietary department did not maintain the completed sanitation checklists.</p> <p>3. During the initial tour of the kitchen on 6/10/24 at 10:45 a.m., there was 1-unsealed and not dated box of rice on the shelf beneath the food preparation table. An observation of the walk-in cooler revealed 1-opened box with an opened bag of pork loin that was not dated; 1-resealed plastic bag of boiled eggs that was not dated, on the floor beneath the shelf; and 1-opened container of pasteurized liquid egg that was not dated. The walk-in freezer consisted of 10-plastic bags of unidentifiable frozen items, not dated or labeled (8-resealed and 2-not sealed).</p> <p>4. During a kitchen observation on 6/12/24 at 1:15 p.m., 2 of 5 dietary staff were observed with exposed/uncovered facial hair ranging from 1/2 inch to 1 inch in length. The two staff were noted to perform various food service tasks including meal production and service without hair coverings over their facial hair.</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42007</p> <p>Based on record review and staff interviews, the facility failed to document providing education of the influenza vaccine pneumococcal vaccine and the resident's or resident representative's refusal to receive the pneumococcal vaccine for 1 of 5 residents reviewed for immunizations (Resident #182).</p> <p>Findings included:</p> <p>Resident #182 was admitted to the facility on [DATE].</p> <p>The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #182 was severely impaired cognitively.</p> <p>There was no documentation in the electronic medical record (EMR) Resident #182 had received the pneumococcal vaccine at the facility. There was also no reported history of Resident #182 receiving a pneumococcal vaccine outside of the facility prior to being admitted .</p> <p>The facility was unable to provide written documentation Resident #182 or Resident #182's Representative had received education to consent to receive or refusal of administration of pneumococcal vaccine.</p> <p>Attempts to interview Resident #182's Responsible Party were unsuccessful.</p> <p>During an interview with the Infection Preventionist on 6/14/24 at 9:12am, she stated that she had worked in that role since July 2023 and was currently also acting as the Staff Development Coordinator. She stated that she had been working on making sure all residents had an updated Covid vaccine and a yearly influenza vaccine and had not focused as much on their pneumococcal status. She added that, previously, an agency nurse filled in the position, and she had been unable to locate several refusal forms for vaccines.</p> <p>During an interview with the Corporate Nurse Consultant on 6/14/2024 at 10:15am, she stated that she was also unable to locate any documentation of consent or refusal of the pneumococcal vaccine by Resident #182 or Resident #182's representative. She added the facility should have obtained written consent or refusal for all vaccines and that should have been a permanent part of their medical record.</p>

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<p>F 0924</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Put firmly secured handrails on each side of hallways.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20906</p> <p>Based on observations, staff interviews and record review, the facility failed to ensure the handrails in the facility corridors were properly secured to the walls, repaired and free from sharp edges on 3 of 4 floors where handrails were present.</p> <p>The findings included:</p> <p>An observation was conducted on 6/11/24 at 12:42 PM to 1:00 PM, revealed on the 500 floor the handrails were detached from the walls and needed repairs due to broken/cracked support brackets and missing end caps in the corridor joining rooms 503, 507, 511, 514, 519, 520, 526, 527 on the hallways. The end of the handrails had sharp edges that were not covered by the endcaps. Staff and residents were observed using the handrails in the current condition.</p> <p>An observation was conducted on 6/11/24 at 1:30 PM to 1:45 PM on the 300 floor, revealed the unit handrails in the corridor joining the rooms 321, 326, 327 and near the janitor hall closet close to the dining room were loose, detached from the walls and needed repairs due to broken/cracked handrails and support brackets that had sharp or exposed edges without endcaps.</p> <p>An observation was conducted on 6/11/24 at 2:00PM to 2:16 PM on the 200 floor revealed the handrails in the corridor joining the rooms 200, 202, 204, 208, 210 and 226, the handrails were loose and detached from the wall with small unpatched holes in the wall. There were several broken/cracked support brackets that had exposed sharp edges and exposed screws. The end caps were missing on the handrail at room [ROOM NUMBER] near the elevators.</p> <p>A follow-up observation was conducted on 6/12/24 at 2:10 PM to 2:25 PM, revealed the identified handrails in the 200 floor 300 floor and 500 floor remained in the same condition and had not been repaired. Staff and residents continued to use the handrails for support during mobilization on the units.</p> <p>An interview was conducted on 6/12/24 at 2:27pm, the Maintenance Director stated he was aware of the condition of the handrails and the repairs or replacement of the broken handrails. He stated he had submitted an invoice for replacement parts for the handrails for some of the handrails that have already been replaced a few months ago. However, he further stated he did not have a system in place to monitor, replace or recheck any of the newly broken handrails. The Maintenance Director presented an invoice for new handrail parts effective on 6/14/24.</p> <p>An interview was conducted on 6/14/24 at 8:00 AM, the Administrator who stated the facility Environmental Service Director and Maintenance Director were responsible for ensuring the facility was clean and structural repairs were completed for the safety of all the residents. She included a handrail and resident room audits would be done for repairs and replacement immediately based on the recent invoice dated 6/14/24.</p>		