STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345110	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Care of Waynesville	360 Old Balsam Road Waynesville, NC 28786

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50045 Based on record review, family, resident, staff, and provider interviews the facility failed to notify the emergency contacts when a resident (Resident #280) had a change in condition and was sent to the emergency room . Furthermore, the facility failed to notify the provider of significant weight gain for a resident (Resident #18) that required diuretic medication. This deficient practice occurred for 2 of 2 sampled residents reviewed for notification of change. The findings included: 1. Resident #280 was admitted to the facility on [DATE] with diagnoses which included a fracture of the upper and lower end of the right fibula (bone in the lower leg), type 2 diabetes, atrial fibrillation (irregular heart rate), and heart disease. A review of the on-call physician correspondence initiated by Nurse #1 on 3/5/2024 revealed Resident #280 was lethargic, barely arousable, even with sternal rub. Also, that staff states she was very 'sleepy' today. Nurse Practitioner #2 had advised Nurse #1 to send Resident #280 to the emergency room at 6:43 pm. An interview was conducted on 4/30/2024 at 10:41 am with Nurse #1. Nurse #1 reported when she performed her rounds on 3/5/2024 at 5:00 pm, Resident #280 she was only responsive to painful stimuli, she contacted the on-call physician, and received orders around 6:30 pm to transfer Resident #280 to the hospital. She reported she had not notified Resident #280's Representative of the change in condition or that Resident #280 was being transferred to the hospital. Nurse #1 reported she gave the report to Paramedic #1 at 6:30 pm and was under the impression that he was going to call Resident #280's emergency contacts. Review of Paramedic #1's (employed by the facility and functioning as a nurse) note dated 3/5/2024 at 9:19 pm revealed Paramedic #1 had attempted to call Resident #280's family and he had left a voicemail for them to call the facility. An interview was conducted on 4/29/2024 at 11:02 am with Paramedic #1. Paramedic #1 reported he was unable to remember specific events from 3/5/2024 with Resident #280 and reported he charted all his interventions in the nurse's note. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345110	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024
NAME OF PROVIDER OR SUPPLIER Autumn Care of Waynesville		STREET ADDRESS, CITY, STATE, ZIP CODE 360 Old Balsam Road Waynesville, NC 28786	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A follow-up interview was conducted on 5/8/2024 at 12:33 pm with Paramedic #1(employed by the facility and functioning as a nurse). Paramedic #1 reported he had only attempted to contact the first emergency contact for Resident #280 one time on 3/5/2024. He reported he had left a generic message (including his name, where he was calling from) for the Resident Representative to call him back because he was unsure if he had the correct number. Paramedic #1 stated he did not receive a return call and does not recall if he told the oncoming nurse during report that he had left a message for the family to call back. He reported he had not made any further attempts to call the Resident Representative or other emergency contacts for Resident #280. An interview was conducted on 5/2/2024 at 3:46 pm with Resident #280's Representative. The Representative reported she had not received a phone call or voicemail from Nurse #1 or Paramedic #1 on 3/5/2024. She reported she was not aware Resident #280 had been taken to the hospital until an Intensive Care Unit (ICU) nurse from the hospital had called her on 3/6/2024 to let her know Resident #280 was admitted to ICU. She reported she was so upset that she had not been notified earlier. An interview was conducted on 5/3/2024 at 10:15 am with the Director of Nursing (DON). The DON reported when a resident had a change in condition or if a resident had to be transferred to the hospital, nursing staff should notify the family as soon as possible. She was aware that Nurse #1 had not called Resident #280's family when Resident #280 was found only responsive to painful stimuli and reported that she should have called the first emergency contact. She reported Paramedic #1 tried to call Resident #280's first emergency contact and he had left a voicemail for them to call the facility upon receipt. She reported Paramedic #1 had not attempted to call the emergency contact again or call the second emergency contact. The DON stated if the first emergency contact could not be reached, staff should attempt to call the second emergency contact. An interview was conducted on 5/3/2024 at 10:27 am with the Administrator. The Administrator stated nursing staff should notify the family immediately when there was a change in resident condition or if a resident was transferred to the hospital. He reported if the first emergency contact could not be reached, nursing staff should attempt to call the second. He was not aware that Nurse #1 had not called Resident #280's family when the resident was found only responsive to painful stimuli and was not aware Paramedic #1 had only called the first emergency contact once and had not attempted to call the second emergency contact at all. 50046 2. Resident #18 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus, coronary artery disease, and hypertension. Physician records and active physician orders revealed she also had a diagnosis of edema (swelling in the extremities). The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #18 was cognitively intact and coded as receiving diuretic medication (a medication that helps remove excess fluid from the body). Review of Resident #18's active physician orders revealed an order dated 3/24/24 for Furosemide (diuretic) tablet 40 milligrams (mg) give one tablet by mouth two times a day for edema. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #18's electronic medication record (EMR) was completed on 4/28/24 and revealed Resident #18's weight had been monitored monthly by the facility. She had a weight documented on 3/5/24 of 254.6 pounds (lbs.) and on 4/4/24 she had a weight of 272 lbs. documented. The facility obtained a reweight weight on 4/5/24 that was recorded as 273.4 lbs. Resident #18 had a 7.38 % (18.8 lbs.) weight gain in a 30-day period. Review of the provider progress notes and nursing notes were reviewed from 4/1/24 through 4/28/24 and revealed no documentation that the provider had been notified of Resident #18's weight gain or increased edema. Review of the Registered Dietician's (RD) progress note date 4/18/24 stated Resident #18 had triggered for a significant weight gain since 3/5/24 and the weight gain had been confirmed with a reweight. Her note mentioned Resident #18 received diuretic medication. The RD note stated NP/ MD aware and that she would ask the Nurse Practitioner (NP)/ Medical Doctor (MD) to review Resident #18's antidepressant medications that could have an effect on her appetite. The RD note indicated a plan to continue to monitor Resident #18's intake, weights, and labs. An interview was performed on 5/1/24 at 2:02 PM with the QA nurse. She stated weights were reviewed during the IDT meetings on Fridays. She stated she would usually give the NP or MD the weight log sheet for them to look over when they were at the facility and then the NP or MD would give verbal orders addressing weight loss/ gain. She stated she did not keep the weight log and the NP/ MD did not sign the weigh log indicating they had reviewed the log. She stated she handed the log to the NP or MD and then they handed the log back to her. She stated she did not specifically review the weights with the NP or MD and discuss the residents who had weight loss or gain. She said if a specific resident had a large weight gain or loss, she would tell the NP or MD that it happened, and I have to go with what they tell me or don't tell me. She stated she did not remember talking to the NP or MD and notifying them of Resident #18's significant weight gain or talking to them about the weight gain. The QA nurse stated she remembered discussing Resident #18's significant weight gain during the IDT meeting. She stated if a resident had a significant weight gain generally the NP/ MD would check labs or would increase the resident diuretic, would change to daily or weekly weight monitoring if weight gain was related to fluid. She stated Resident #18 had complained to her of edema on 4/28/24 and that she had notified the NP the next day on 4/29/24 that Resident #18 needed to be seen. The QA nurse stated a significant weight gain would be something a resident would need to be seen by the NP/ MD for. She stated she was unsure what happened that the NP/ MD was not notified. The QA nurse stated, I guess I somehow or another dropped the ball on that and letting the NP know that the resident (Resident #18) needed to be seen. The QA nurse stated the NP should have been notified of Resident #18's weight gain sooner than 4/29/24. An interview was conducted on 5/1/24 at 1:43 PM with the Medical Director. He stated he was not aware of Resident #18's large weight gain. He said she had a history of having issues with edema in the past. He said the facility should have notified him or the NP sooner than a month and that this was probably too long to wait to notify someone for significant weight gain. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was performed on 5/1/24 at 3:11 pm with the DON. She stated Resident #18's weight gain should have been discussed in the morning clinical meeting and then weekly IDT meeting. She stated the IDT meeting focus with weights was weight loss because that was worse, but gain needed to be monitored too. She stated Resident #18 did not have heart failure but did have lots of edema. The DON stated it should be nursing who looked at residents with weight gain and edema to look at the clinical aspect for why the resident might be gaining weight. She stated Resident #18's weight gain should had been conveyed to the NP/ MD that week. She stated Resident #18 should probably be on weekly weight monitoring. An interview was completed on 05/02/24 at 10:31AM with the Administrator. He said clinically he did not know what happened in the incident and was not sure if the weight gain was because of Resident #18 retaining a lot of fluid. He stated in the IDT meeting he remembered Resident #18's weight gain being discussed. The Administrator stated the provider should have been notified sooner to evaluate her clinically for things like diet change, lab work, edema, or the need for an increase in her diuretic medication. An interview was performed on 05/02/24 at 12:12 PM with the NP. She said she was not notified about Resident #18's weight gain. She stated she did not realize Resident #18 had gained that much weight. The NP stated if she had been notified of Resident #18's weight gain at the beginning of April when the weight gain was noted by the facility, she would have assessed Resident #18. The NP stated she would have done a B-type natriuretic peptide (BNP) test (a test Providers use to diagnose and monitor heart failure) to check and make sure it was in range and was not causing the weight gain. She stated this was what she would usually do if a patient had a weight gain of 3-5 lbs. in a week or a significant weight gain. The NP stated that Resident #18 had increased edema to both of her lower extremities when she saw her on 4/29/24. The NP stated if a resident had large weight gains their weight should be monitored at least weekly for weight gains. The NP stated she wanted to be notified if a resident had a 3-5 lbs. weight gain in a week.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50045 Based on record reviews, staff, and Medical Director (MD) interviews the facility failed to protect a Resident's right to be free from neglect when Resident # 280 experienced a medical emergency and emergency medical services (EMS) were not provided. The resident was only responsive to painful stimuli on [DATE] around 5:00 PM and 911 was not initiated until 8:10 PM. Resident #280 was transferred to the hospital and diagnosed with metabolic encephalopathy (a problem in the brain caused by a chemical imbalance) due to urinary tract infection (UTI) and possibly due to cellulitis/infected lower extremity wounds or hypoglycemia. On [DATE] Resident #280 was discharged to hospice care for comfort care. On [DATE] Resident #280 expired. This occurred for 1 of 3 residents reviewed for neglect. Immediate jeopardy began on [DATE] when EMS was not initiated for a medical emergency. Immediate jeopardy was removed on [DATE] when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity of D (no actual harm with a potential for minimal harm that is not immediate jeopardy) to ensure education is completed and monitoring systems put into place are effective. The findings included: 1. Resident #280 was admitted to the facility on [DATE] with diagnoses which included a fracture of the upper and lower end of the right fibula (bone in the lower leg), type 2 diabetes, atrial fibrillation (irregular heart rate), and heart disease. Resident #280 was not receiving hospice services. A review of the care plan dated [DATE] revealed Resident #280 was at risk for hypoglycemia with a goal to be free of signs and symptoms of hypoglycemia. Interventions included for nursing staff to assess blood sugars as per order and as needed for symptoms of hypoglycemia/hyperglycemia. The care plan further revealed Resident #280 was at risk for altered cardiac and respiratory status with a goal that Resident #280 would not have a preventable crisis. Interventions included for nursing staff to monitor oxygen saturations as needed, to monitor for signs and symptoms of decreased cardiac output (rapid, slow, weak, or diminished pulse, hypotension, hypertension, dizziness, syncope, dyspnea, chest pain, restlessness, cyanosis, alerted mental status, congestion, or shortness of breath). An admission Minimum Data Set (MDS) dated [DATE] revealed Resident #280 was cognitively intact and had not exhibited any behaviors. She was not documented as being on hospice services or receiving insulin. A review of the on-call physician correspondence initiated by Nurse #1 on [DATE] at 5:30 pm as stated by Nurse #1 revealed Resident #280 was lethargic, barely arousable, even with sternal rub. Also, that staff states she was very 'sleepy' today. Nurse Practitioner #2 had advised Nurse #1 to send Resident #280 to the emergency room at 6:43 pm. Nurse Practitioner #2 was unable to be interviewed. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was conducted on [DATE] at 10:41 am with Nurse #1. Nurse #1 reported she worked first shift (6:30 am to 6:30 pm) and usually floated between halls. She reported on [DATE] she floated to 200-hall (Resident #280's hall) at 2:30 pm and relieved Nurse #2. Nurse #2 informed Nurse #1 that Resident #280 had been sleepy all day. Nurse #1 stated after she finished report she took time to get adjusted and started passing medications. She reported she did not go check on Resident #280 until 5:00 pm, at which time the resident was only responsive to painful stimuli. Nurse #1 reported she obtained vital signs after she realized Resident #280 was only responsive to painful stimuli and stated she had not checked her blood sugar. She reported she consulted their on-call telehealth provider around 6:00 pm. Nurse #1 reported the on-call provider had advised her to send Resident #280 to the emergency room around 6:30 pm. She reported she then gave the report to Paramedic #1, printed off Resident #280's information for EMS, and left for the day. She reported she had not notified Resident #280's family or called EMS because she was under the assumption that Paramedic #1 would. Nurse #1 stated she gave shift report to Paramedic #1 (employed by the facility and functioning as a nurse) on [DATE] at 6:30 pm when Paramedic #1 started his shift. Nurse #1 stated she felt as though she had neglected Resident #280 because she should have not relied on Paramedic #1 to initiate EMS and complete her work. Vital signs were entered on [DATE] at 6:41 pm (which were obtained at 5:30 pm by Nurse #1 per her report). Resident #280's blood pressure was ,d+[DATE], heart rate was 62 beats per minute, respiration rate was 16 breaths per minute, oxygen saturation was 91% on room air, and her temperature was 96.5 degrees Fahrenheit axillary (under the arm). Further review of Resident #280's medical record revealed no ongoing assessment, vital signs, or blood glucose monitoring from 5:30 pm until she was transferred by EMS at 8:13 pm. A review of a nursing note completed by Paramedic #1 (employed by the facility) on [DATE] at 9:19 pm revealed Resident #280 had a change in condition in the last 24 hours and he was told in shift change report that Resident #280 was only responsive to painful stimuli. He documented he had called EMS at 8:00 pm to see where they were and was told by EMS that they had never been contacted, he then requested an ambulance and sent Resident #280 to the emergency room . A telephone interview was conducted on [DATE] at 11:02 am with Paramedic #1. Paramedic #1 reported he was not able to remember the events involving Resident #280 on [DATE]. He stated he would have documented any assessment, monitoring, vital signs, and/or interventions in his nursing note. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A follow-up telephone interview was conducted on [DATE] at 4:09 pm with Paramedic #1. Paramedic #1 reported he started his shift at 6:30 pm on [DATE] and received report from Nurse #1. Paramedic #1 stated Nurse #1 reported Resident #280 was only responsive to a sternal rub. Paramedic #1 reported Nurse #1 had contacted the on-call provider, had received orders from the on-call provider to send Resident #280 to the emergency room , and asked him to check on Resident #280 while she gathered the paperwork for transfer. Paramedic #1 reported he assessed Resident #280 at 6:30 pm, at which time Resident #280 was able to communicate verbally. Paramedic #1 stated he assessed Resident #280's heart sounds, lung sounds, and pulses however he had not reassessed Resident #280's vital signs because she appeared stable. Paramedic #1 reported he was under the impression Nurse #1 had called EMS. Paramedic #1 reported he started his medication pass and checked the hall to see if an EMS stretcher was in the hall. Paramedic #1 reported he called to check the status of EMS at 8:00 pm at which time he was told EMS had never been notified. Paramedic #1 stated at that time he requested an ambulance, which arrived shortly after, and transferred Resident #280 out of the facility. He reported he failed to document his assessments because he had forgotten. Paramedic #1 stated Nurse #1 should have initiated EMS prior to leaving the facility. He did not speak to the incident as neglect. A telephone interview was conducted on [DATE] at 10:57 am with EMS Personnel at dispatch. The EMS Personnel reported a facility staff member had called to initiate EMS services on [DATE] at 8:10 pm and an EMS unit arrived on scene at 8:13 pm. Review of the Emergency Medical Services (EMS) assessment dated [DATE] at 9:03 pm revealed Resident #280 was found to be unresponsive and hypoglycemic, with a blood sugar of 74 mg/dL, and was transferred out of the facility at 8:13 pm to the emergency room . A review of the emergency room Physician note dated [DATE] at 3:32 am revealed Resident #280 had arrived at the emergency roiagnom on [DATE] with altered mental status. The facility had reported to EMS that Resident #280 was normally awake however she was much more somnolent and not able to swallow her pills. The emergency room Physician documented Resident #280 was unable to participate in a neurological exam, remained obtunded, and was not able to follow any commands. EMS had furthered reported to the emergency room Physician Resident #280's blood sugar was 74 and she had likely not been eating or drinking all day. Documentation further revealed Resident #280 was admitted with a primary diagnosis of metabolic encephalopathy due to urinary tract infection (UTI) and possibly due to cellulitis/infected lower extremity wounds or hypoglycemia. A review of the hospital physician discharge summary dated [DATE] revealed Resident #280 had continued to decline. A discussion was had with Resident #280's Representative to keep her comfortable and a Do Not Resuscitate (DNR) order was implemented. Resident #280 was then discharged to hospice. A review of the death certificate revealed Resident #280 expired on [DATE] with the immediate cause of End of Life Comfort Measures with Hospice Care. An interview was conducted on [DATE] at 6:00 pm with the Director of Nursing (DON). The DON reported Resident #280 was found unresponsive and with stable vital signs on [DATE]. The DON reported Nurse #1 made an error by not initiating EMS and that Nurse #1 should have never left her shift without calling EMS. The DON stated Nurse #1 and Paramedic #1 should have performed head-to-toe assessments, ongoing assessments, and ongoing vital signs (including blood sugars). The DON reported she had not felt as though Nurse #1 or Paramedic #1 neglected Resident #280. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was conducted on [DATE] at 6:08 pm with the Administrator. The Administrator reported he had not been made aware of the events leading up to Resident #280 being transferred to the hospital on [DATE] until the DON informed him on [DATE]. He reported Nurse #1 should not have left the building without initiating EMS for Resident #280 and that there was a huge delay in care. He reported he was not aware that Nurse #1 had not performed a head-to-toe assessment, ongoing assessment, and ongoing vital signs (including blood sugar checks). The Administrator reported he had not felt as though Nurse #1 or Paramedic #1 neglected Resident #280. An interview was conducted on [DATE] at 1:22 pm with the MD. The MD reported he had assessed Resident #280 on the morning of [DATE] and reported Resident #280 was alert at that time. The MD stated he was not aware of the delay in initiating EMS and the lack of monitoring until today ([DATE]) and reported Resident #280 should have been monitored until she was transferred to the hospital. The Administrator was notified of Immediate Jeopardy on [DATE] at 6:08 pm. The facility provided the following Immediate Jeopardy removal plan: Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance: Nurse #1 reported she was notified during report from Nurse #2 at 2:30 pm that Resident #280 had been excessively sleepy that morning ([DATE]). Nurse #1 reported she had not assessed Resident #280 until 5:00 pm, at which time she was only responsive to painful stimuli. Nurse #1 contacted the on-call Medical Service to have Resident #280 assessed at 6:00 pm and was advised at 6:30 pm to transfer her to the hospital. Nurse #1 only checked Resident #280's vital sings once, did not obtain oxygen saturations or blood sugar and did not activate 911 when resident was found to be unresponsive at 5 pm. Nurse #1 stated she printed out the medical record after she had given report to Paramedic #1. Nurse #1 reported she was under the assumption that Paramedic #1 would contact Emergency Medical Services (EMS). Paramedic #1 completed walking rounds of his assigned unit on [DATE] at 8:00 pm and realized that Resident #280 had not be transported to the hospital and contacted EMS at 8:10 pm, at what time he was informed that EMS was never called for transport. EMS arrived on [DATE] at 8:13 pm and transported Resident #280 to the hospital where she was diagnosed with acute metabolic encephalopathy related to sepsis from urinary tract infection versus bacteremia from wounds, dehydration, and hypoglycemia. Resident #280 was transferred to hospital on [DATE] and did not return to the facility. On [DATE] the Regional Director of Clinical Services educated Nurse #1 and Paramedic #1 on effective communication between staff during a Medical Emergency, timely assessment and monitoring and assessment of change of condition including Blood Pressure, Pulse, Respirations, Temp, oxygen saturation and Blood Sugar if resident is a Diabetic. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] the Director of Nursing or Designee immediately audited the Situation, Background, Assessment and Recommendation and progress notes of residents sent to hospital in the last 30 days to confirm that no delay in assessment, monitoring or transfer to hospital occurred. No negative findings were found. On [DATE] the Director of Nursing or Designee audited Nursing progress notes from the last 72 hours to ensure no change of conditions were found and not followed up on in a timely manner. No negative findings were found. On [DATE] the Social Worker/Administrator or Designee interviewed residents with a BIMS of 12 or above regarding if they have had a change of condition that was not followed up on immediately, if they had any concerns of neglect and if they felt they had a delay in treatment. No negative findings were noted. The Director of Nursing or Designee audited Nursing progress notes from the last 72 hours of residents with a BIMS of less than 12 to ensure residents had no change of condition that was not followed up on immediately. No negative findings were noted. Specify the action of the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete. On [DATE] the Director of Nursing or Designee interviewed all nursing and therapy staff regarding knowledge of any residents having change of conditions in the last 72 hours that were not addressed and if they were aware of any resident neglect. No negative findings were noted. On [DATE] the Director of Nursing or Designee educated all staff on reporting any change of condition to the nurse immediately. The Staff that were not working on [DATE] will be educated prior to start of their next shift. On [DATE] the Director of Nursing or Designee educated all staff on effective communication between staff members during a Medical Emergency. The Staff that were not working on [DATE] will be educated prior to start of their next shift. On [DATE] the Director of Nursing or Designee educated all Licensed Nurses and Paramedics on observing and assessing residents for change of condition from baseline and communicating to provider for follow up and treatment in a timely manner. The Licensed Nurses and Paramedics that were not working on [DATE] will be educated prior to the start of their next shift. On [DATE] the Director of Nursing or Designee educated all Licensed Nurses and Paramedics on recognizing serious decline of cognition and responsiveness of resident as an emergent occurrence and to contact provider and transfer to hospital immediately. The Licensed Nurses and Paramedics that were not working on [DATE] will be educated prior to the start of their next shift. On [DATE] the Director of Nursing or Designee educated Licensed Nurses and Paramedics on timely assessment and monitoring and assessment of change of condition including Blood Pressure, Pulse, Respirations, Temp, oxygen saturation and Blood Sugar if resident is a Diabetic and the Abuse and Neglect Policy. The Licensed Nurses and Paramedics that were not working on [DATE] will be educated prior to the start of their next shift. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] the Director of Nursing or Designee educated all staff on the Abuse and Neglect Policy. The Staff that were not working on [DATE] will be educated prior to start of their next shift. On [DATE] Ad Hoc QAPI was completed regarding Abuse and Neglect. In addition, effective communication between staff in Medical Emergencies, timeliness of assessment and monitoring of change of conditions to include transferring resident to hospital. On [DATE] the Regional Director of Clinical Services educated the Administrator, Director of Nursing, Assistant Director of Nursing, Scheduler and Human Resources on the Orientation Process that will include education on recognizing change of condition, effective communication during a Medical Emergency, timely assessment and monitoring and assessment of change of condition including Blood Pressure, Pulse, Respirations, Temp, oxygen saturation and Blood Sugar if resident is a Diabetic. The Director of Nursing or Designee will ensure newly hired Licensed Nurses or Paramedics receive education on the Effective Communication during a Medical Emergency, Abuse and Neglect Policy and timely assessment and monitoring and assessment of change of condition including Blood Pressure, Pulse, Respirations, Temp, oxygen saturation and Blood Sugar if resident is a Diabetic in Orientation. The Director of Nursing or Designee will ensure Agency Staff receive education on Effective Communication during a Medical Emergency, the Abuse and Neglect Policy and timely assessment and monitoring and assessment of change of condition including Blood Pressure, Pulse, Respirations, Temp, oxygen saturation and Blood Sugar if resident is a Diabetic prior to first shift of working in facility. Immediate jeopardy removal date: [DATE] The credible allegation was validated [DATE] onsite. Staff interviews revealed that NAs, Medication Technicians, and Nurses had received in-service education regarding abuse and neglect which included how to keep the residents safe, reporting the issue to the immediate supervisor, reporting change in condition, and effective communication among staff. Nursing staff also received specific education related to neglect and how/who to report suspensions of neglect. A review of education revealed staff had received neglect training. The immediate jeopardy removal date of [DATE] was validated.

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49160 Based on record review, Resident Representative, Ombudsman and staff interviews, the facility failed to provide a written notice of transfer/discharge to the Resident and Resident Representative and failed to send a copy of the notice to the local Ombudsman for 1 of 2 residents (Resident #280) reviewed for discharge. The findings included: Resident #280 was admitted to the facility on [DATE]. The admission Minimum Data Set, dated dated dated [DATE] indicated Resident #280 was cognitively intact. Resident #280 was discharged to the hospital on 3/5/2024 and did not return to the facility. A review of the record revealed Resident #280 was her own responsible party and also had a Resident Representative listed as a contact. A review of the nurse's note dated 3/5/2024 at 9:19 PM written by Paramedic #1 (who worked as a nurse in the facility on 3/5/24) revealed Resident #280 had a change in condition that required transfer to the emergency department (ED). Paramedic #1 called the Resident Representative and left a voicemail. The medication administration record (MAR) and face sheet were sent with Resident #280 to the hospital. A telephone interview was conducted with Paramedic #1 on 5/8/2024 at 12:33 PM. He stated on 3/5/2024 he worked as a nurse and sent Resident #280 to the hospital due to a change in condition. When Resident #280 was transferred to the hospital, Paramedic #1 explained he sent the MAR and face sheet with the Resident to the hospital. He stated there was not a notice of transfer/discharge and he was not familiar with the form. A review of Resident #280's electronic medical record revealed a notice of transfer/discharge form was completed by the Business Office Manager on 3/6/2024 and sent to Resident #280's home address via certified mail. A telephone interview was conducted with Nurse #1 on 5/8/2024 at 8:28 AM. Nurse #1 indicated on 3/5/2024, at the end of her shift, she had received an order to transfer Resident #280 to the ED for evaluation. She revealed she did not notify the Resident Representative. She stated she prepared a face sheet and the MAR. Nurse #1 indicated she was not familiar with the notice of transfer/discharge form. (continued on next page)

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	A telephone interview was conducted with the Business Office Manager on 5/8/2024 at 8:41 AM. She stated when a resident was transferred to the ED the nurse on duty was responsible for completing the notice of transfer/discharge form. She revealed on the next business she completed a new form and sent it to the Resident/Resident Representative via certified mail. She indicated she completed a notice of transfer/discharge form for Resident #28 on 3/6/2024. The Business Office Manager stated she sent the notice via certified mail, to the resident's home address and she had the tracking information provided by the postal service. A telephone interview was conducted with the Director of Nursing on 5/8/2024 at 11:05 AM. She indicated the nurse on duty was responsible for completing the notice of transfer/discharge form as part of the packet of information that was sent with the resident to the hospital. A telephone interview was conducted with the Ombudsman on 5/8/2024 at 2:27 PM. The Ombudsman stated she had not received any transfer/discharge notices from the facility since January 2024 including the notice for Resident #280. A follow-up telephone interview was conducted with the Business Office Manager on 5/8/2024 at 4:00 PM. She indicated she had not been sending a copy of the notice of transfer/discharge to the Ombudsman because she was never told that was required. An interview was conducted with the Administrator on 5/8/2024 at 4:57 PM. The Administrator stated the nurse on duty was responsible for completing a notice of transfer/discharge to send with a resident who was transferred to the ED. The Business Office Manager then completed a new notice of transfer/discharge the next business day and sent it to the Resident/Resident Representative via certified mail. He indicated the facility had not sent copies of the transfer/discharge notices to the Ombudsman. A telephone interview was conducted with the Resident Representative on 5/9/2024 at 9:40 AM. The Resident Representative indicated she received the transfer/discharge notice on 3/26/2024 when she went to the post office and retrieved Resident #280's mail.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50045 Based on observations, record review and Resident, staff, Nurse Practitioner (NP), and Medical Director (MD) interviews nursing staff failed to identify the seriousness of a change in condition for a resident with a diagnosis of insulin dependent diabetes and provide thorough ongoing monitoring and comprehensive assessments. On [DATE] at 2:30 PM Nurse #2 reported to Nurse #1 Resident #280 was sleepy all day. Nurse #1 did not assess Resident #280 until 5:00 PM and observed the resident was only responsive to painful stimuli and obtained a set of vital signs but did not check her blood sugar. The on-call provider was contacted, and Nurse #1 was instructed to transfer Resident #280 to the emergency room . Lack of effective communication between Nurse #1 and oncoming Paramedic #1 (employed by the facility and functioning as a nurse) resulted in Emergency Medical Services (EMS) not being contacted until 8:10 PM. Resident #280 was unresponsive with a blood sugar of 74 and was transferred to the emergency room . Resident #280 was admitted to the hospital with a primary diagnosis of metabolic encephalopathy (brain dysfunction), was transferred to hospice on [DATE], and expired on [DATE]. Resident #282 was admitted on [DATE] and the facility failed to administer sliding scale insulin (insulin dose based on predefined blood sugar ranges) per the hospital discharge summary or monitor blood sugar levels per the physician orders for a resident with a diagnosis of insulin dependent diabetes. On [DATE] Resident #282 reported extreme thirst and requested for her blood sugar to be checked. Resident #282's blood sugar was 548 (normal range 80 to 130) and a blood sugar greater than 300 could indicate diabetic ketoacidosis which is a dangerous and life-threatening complication of diabetes that occurs when your body does not get enough insulin.) The facility failed to assess a resident for the cause of significant weight gain and edema (swelling caused by too much fluid trapped in the body's tissues) (Resident #18). The deficient practice occurred for 3 of 3 sampled residents (Residents #280, #282 and #18). Immediate jeopardy for Resident #280 began on [DATE] when nurses failed to identify and effectively respond to a medical emergency. Immediate jeopardy was removed on [DATE] when the facility implemented a credible allegation of immediate jeopardy removal. Immediate jeopardy for Resident #282 began on [DATE] when the facility failed to administer sliding scale insulin or monitor blood sugar levels. Immediate Jeopardy was removed on [DATE] when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity of D (no actual harm with a potential for minimal harm that is not immediate jeopardy) to ensure education is completed and monitoring systems put into place are effective. Example #3 was cited at t lower scope and severity of D. The findings included: 1. Resident #280 was admitted to the facility on [DATE] with diagnoses which included a fracture of the upper and lower end of the right fibula (bone in the lower leg), type 2 diabetes, atrial fibrillation (irregular heart rate), and heart disease. Resident #280 was not receiving hospice services. A review of Resident #280's physicians orders from [DATE] through [DATE] revealed the following: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A standing order dated [DATE] through [DATE] for blood glucose levels to be checked in the morning and at night for the first 4 days and to inform MD of results. Review of Resident #280's physician orders and documentation from [DATE] through [DATE] revealed no further orders for blood sugars to be checked and no notification was made to the MD regarding blood sugars. The Medication Administration Record (MAR) for January revealed the following blood sugars: [DATE] at 9:44 pm Resident #280's blood sugar was 175 mg/dL. [DATE] at 5:17 am Resident #280's blood sugar was 137 mg/dL. [DATE] at 4:45 pm Resident #280's blood sugar was 166 mg/dL. [DATE] at 5:06 pm Resident #280's blood sugar was 158 mg/dL. [DATE] at 6:21 am Resident #280's blood sugar was 136 mg/dL. [DATE] at 4:46 pm Resident #280's blood sugar was 164 mg/dL. [DATE] at 6:10 am Resident #280's blood sugar was 135 mg/dL. An order dated [DATE] through [DATE] for Insulin Glargine (long-acting insulin) Subcutaneous Solution 16 units to be injected subcutaneously (under the skin) at bedtime for type 2 diabetes. A review of Resident #280's Medication Administration Record (MAR) from [DATE] to [DATE] revealed initialed administrations for Insulin Glargine 16 units subcutaneously daily. A review of the care plan dated [DATE] revealed Resident #280 was at risk for hypoglycemia with a goal to be free of signs and symptoms of hypoglycemia. Interventions included for nursing staff to assess blood sugars as per order and as needed for symptoms of hypoglycemia/hyperglycemia. The care plan further revealed Resident #280 was at risk for altered cardiac and respiratory status with a goal that Resident #280 would not have a preventable crisis. Interventions included for nursing staff to monitor oxygen saturations as needed, to monitor for signs and symptoms of decreased cardiac output (rapid, slow, weak, or diminished pulse, hypotension, hypertension, dizziness, syncope, dyspnea, chest pain, restlessness, cyanosis, alerted mental status, congestion, or shortness of breath). A review of Resident #280's blood sugar summary revealed the last blood sugar obtained was on [DATE] and was 135 milligrams per deciliter (mg/dL) at that time. An admission Minimum Data Set (MDS) dated [DATE] revealed Resident #280 was cognitively intact and had not exhibited any behaviors. She was not documented as being on hospice services or receiving insulin. A review of the breakfast meal intake documented by Nurse Aide (NA #1) revealed Resident #280 ate , d+[DATE]% on [DATE]. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Vital signs were obtained on [DATE] at 12:12 pm by Nurse #2. Resident #280's blood pressure was , d+[DATE], heart rate was 64 beats per minute, respiration rate was 16 breaths per minute, oxygen saturation was 92% via nasal canula at an unknown rate, and her temperature was 97.6 degrees Fahrenheit. An interview was conducted on [DATE] at 11:47 am with Nurse #2. Nurse #2 reported she worked from 6:30 am to 2:30 pm on [DATE] with Resident #280. She reported she vaguely remembered Resident #280 but recalled her being sleepy. She reported she had not thought it was unusual because she had not worked with Resident #280 often. Nurse #2 reported she did not perform or document a head-to-toe assessment on Resident #280 but had obtained vital signs on [DATE] at 12:12 pm and reported her vital signs were stable. An attempt was made to interview Nurse Aide (NA) #1 on [DATE] who worked first shift (6:30 am to 2:30 pm) on [DATE]. NA#1 was unable to recall Resident #280. A review of the lunch intake documented by NA #1 revealed Resident #280 ate ,d+[DATE]% of her meal on [DATE]. A review of the on-call physician correspondence initiated by Nurse #1 on [DATE] at 5:30 pm as stated by Nurse #1 revealed Resident #280 was lethargic, barely arousable, even with sternal rub. Also, that staff states she was very 'sleepy' today. Nurse Practitioner #2 had advised Nurse #1 to send Resident #280 to the emergency room at 6:43 pm. Nurse Practitioner #2 was unable to be interviewed. An interview was conducted on [DATE] at 10:41 am with Nurse #1. Nurse #1 reported she worked first shift (6:30 am to 6:30 pm) and usually floated between halls. She reported on [DATE] she floated to 200-hall (Resident #280's hall) at 2:30 pm and relieved Nurse #2. Nurse #2 informed Nurse #1 that Resident #280 had been sleepy all day. Nurse #1 stated after she finished report she took time to get adjusted and started passing medications. She reported she did not go check on Resident #280 until 5:00 pm, at which time the resident was only responsive to painful stimuli. Nurse #1 reported she obtained vital signs after she realized Resident #280 was only responsive to painful stimuli and stated she had not checked her blood sugar. She reported she consulted their on-call telehealth provider around 6:00 pm. Nurse #1 reported the on-call provider had advised her to send Resident #280 to the emergency room around 6:30 pm. She reported she then gave the report to Paramedic #1, printed off Resident #280's information for EMS, and left for the day. She reported she had not notified Resident #280's family or called EMS because she was under the assumption that Paramedic #1 would. Nurse #1 stated she gave shift report to Paramedic #1 (employed by the facility and functioning as a nurse) on [DATE] at 6:30 pm when Paramedic #1 started his shift. A review of the dinner intake for Resident #280 revealed no recorded on [DATE]. Vital signs were entered on [DATE] at 6:41 pm (which were obtained at 5:30 pm by Nurse #1 per her report). Resident #280's blood pressure was ,d+[DATE], heart rate was 62 beats per minute, respiration rate was 16 breaths per minute, oxygen saturation was 91% on room air, and her temperature was 96.5 degrees Fahrenheit axillary (under the arm). Further review of Resident #280's medical record revealed no ongoing assessment, vital signs, or blood glucose monitoring from 5:30 pm until she was transferred by EMS at 8:13 pm. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review of a nursing note completed by Paramedic #1 (employed by the facility) on [DATE] at 9:19 pm revealed Resident #280 had a change in condition in the last 24 hours and he was told in shift change report that Resident #280 was only responsive to painful stimuli. He documented he had called EMS at 8:00 pm to see where they were and was told by EMS that they had never been contacted, he then requested an ambulance and sent Resident #280 to the emergency room . A telephone interview was conducted on [DATE] at 11:02 am with Paramedic #1. Paramedic #1 reported he was not able to remember the events involving Resident #280 on [DATE]. He stated he would have documented any assessment, monitoring, vital signs, and/or interventions in his nursing note. A follow-up telephone interview was conducted on [DATE] at 4:09 pm with Paramedic #1. Paramedic #1 reported he started his shift at 6:30 pm on [DATE] and received report from Nurse #1. Paramedic #1 stated Nurse #1 reported Resident #280 was only responsive to a sternal rub. Paramedic #1 reported Nurse #1 had contacted the on-call provider, had received orders from the on-call provider to send Resident #280 to the emergency room , and asked him to check on Resident #280 while she gathered the paperwork for transfer. Paramedic #1 reported he assessed Resident #280 at 6:30 pm, at which time Resident #280 was able to communicate verbally. Paramedic #1 stated he assessed Resident #280's heart sounds, lung sounds, and pulses however he had not reassessed Resident #280's vital signs because she appeared stable. Paramedic #1 reported he was under the impression Nurse #1 had called EMS. Paramedic #1 reported he started his medication pass and checked the hall to see if an EMS stretcher was in the hall. Paramedic #1 reported he called to check the status of EMS at 8:00 pm at which time he was told EMS had never been notified. Paramedic #1 stated at that time he requested an ambulance, which arrived shortly after, and transferred Resident #280 out of the facility. He reported he failed to document his assessments because he had forgotten. A telephone interview was conducted on [DATE] at 10:57 am with EMS Personnel at dispatch. The EMS Personnel reported a facility staff member had called to initiate EMS services on [DATE] at 8:10 pm and an EMS unit arrived on scene at 8:13 pm. Review of the Emergency Medical Services (EMS) assessment dated [DATE] at 9:03 pm revealed Resident #280 was found to be unresponsive and hypoglycemic, with a blood sugar of 74 mg/dL, and was transferred out of the facility at 8:13 pm to the emergency room . A review of the emergency room Physician note dated [DATE] at 3:32 am revealed Resident #280 had arrived at the emergency roiagnom on [DATE] with altered mental status. The facility had reported to EMS that Resident #280 was normally awake however she was much more somnolent and not able to swallow her pills. The emergency room Physician documented Resident #280 was unable to participate in a neurological exam, remained obtunded, and was not able to follow any commands. EMS had furthered reported to the emergency room Physician Resident #280's blood sugar was 74 and she had likely not been eating or drinking all day. Documentation further revealed Resident #280 was admitted with a primary diagnosis of metabolic encephalopathy due to urinary tract infection (UTI) and possibly due to cellulitis/infected lower extremity wounds or hypoglycemia. A review of the hospital physician discharge summary dated [DATE] revealed Resident #280 had continued to decline. A discussion was had with Resident #280's Representative to keep her comfortable and a Do Not Resuscitate (DNR) order was implemented. Resident #280 was then discharged to hospice. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review of the death certificate revealed Resident #280 expired on [DATE] with the immediate cause of End of Life Comfort Measures with Hospice Care. An interview was conducted on [DATE] at 11:17 am with the Director of Nursing (DON). The DON reported Resident #280 was found unresponsive and with stable vital signs on [DATE]. She reported Nurse #1 contacted the on-call telehealth provider around 5:00 pm. The DON reported Paramedic #1 checked on Resident #280 around 8:00 pm while he was performing his walking rounds and realized that the ambulance had still not arrived to get the resident. A follow-up interview was conducted on [DATE] at 6:00 pm with the DON. The DON reported Nurse #1 should have never left her shift without calling EMS. An interview was conducted on [DATE] at 6:08 pm with the Administrator. The Administrator reported he had not been made aware of the events leading up to Resident #280 being transferred to the hospital on [DATE] until the DON informed him on [DATE]. He reported Nurse #1 should have not left the building without initiating EMS for Resident #280 and that there was a huge delay in notifying EMS. An interview was conducted on [DATE] at 1:22 pm with the MD. The MD reported he had assessed Resident #280 on the morning of [DATE] and reported Resident #280 was alert at that time. The MD stated he was not made aware of Resident #280's change in condition until after she had been admitted to the hospital. The MD stated he would expect facility staff to notify a provider if a resident had an acute change in mental status. He reported the resident would need to be evaluated and transferred to the hospital for further treatment and evaluation when there was an acute change in mental status to identify and treat the cause. The MD stated he was not aware of the delay in initiating EMS and the lack of monitoring until today ([DATE]). The Administrator was made aware of Immediate Jeopardy on [DATE] at 6:08 pm. The facility provided the following credible allegation of Immediate Jeopardy removal: Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome because of the noncompliance: Nurse #1 reported she was notified during a report from Nurse #2 at 2:30 pm that Resident #280 had been excessively sleepy that morning ([DATE]). Nurse #1 reported she had not assessed Resident #280 until 5:00 pm, at which time she was only responsive to painful stimuli. Nurse #1 contacted the on-call Medical Service to have Resident #280 assessed at 6:00 pm and was advised at 6:30 pm to transfer her to the hospital. Nurse #1 only checked Resident #280's vital signs once, did not obtain oxygen saturations or blood sugar and did not activate 911 when resident was found to be unresponsive at 5 pm. Nurse #1 stated she printed out the medical record after she had given the report to Paramedic #1. Nurse #1 reported she was under the assumption that Paramedic #1 would contact Emergency Medical Services (EMS). Paramedic #1 completed walking rounds of his assigned unit on [DATE] at 8:00 pm and realized that Resident #280 had not been transported to the hospital and contacted EMS at 8:10 pm, at what time he was informed that EMS was never called for transport. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	EMS arrived on [DATE] at 8:13 pm and transported Resident #280 to the hospital where she was diagnosed with acute metabolic encephalopathy related to sepsis from urinary tract infection versus bacteremia from wounds, dehydration, and hypoglycemia. Resident #280 was transferred to hospital on [DATE] and did not return to the facility. On [DATE] the Regional Director of Clinical Services educated Nurse #1 and Paramedic #1 on effective communication between staff during a Medical Emergency, timely assessment, monitoring, and assessment of change of condition including Blood Pressure, Pulse, Respirations, Temp, oxygen saturation and Blood Sugar if resident is a Diabetic. On [DATE] the Director of Nursing or Designee immediately audited the Situation, Background, Assessment and Recommendation and progress notes of residents sent to hospital in the last 30 days to confirm that no delay in assessment, monitoring or transfer to hospital occurred. No negative findings were found. On [DATE] the Director of Nursing or Designee audited Nursing progress notes from the last 72 hours to ensure no change of conditions were found and not followed up on in a timely manner. No negative findings were found. On [DATE] the Social Worker/Administrator or Designee interviewed residents with a BIMS of 12 or above regarding if they have had a change of condition that was not followed up on immediately and if they felt they had a delay in treatment. The Director of Nursing or Designee audited Nursing progress notes from the last 72 hours of residents with a BIMS of less than 12 to ensure residents had no change of condition that was not followed up on immediately. No negative findings were noted. On [DATE] the Director of Nursing or Designee interviewed all nursing and therapy staff regarding knowledge of any residents having change of conditions in the last 72 hours that were not addressed. No negative findings were noted. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete. On [DATE] the Director of Nursing or Designee educated all Certified Nursing Assistants on reporting any change of condition of residents to the nurse immediately. The Director of Nursing or Designee will ensure Certified Nursing Assistants that were not working on [DATE] will be educated prior to their next shift. On [DATE] the Director of Nursing or Designee educated Licensed Nurses and Paramedics on timely assessment and monitoring and assessment of change of condition including Blood Pressure, Pulse, Respirations, Temperature, Oxygen Saturation and Blood Sugar if resident is a Diabetic. The Licensed Nurses and Paramedics that were not working on [DATE] will be educated prior to their next shift. The Director of Nursing or Designee will ensure Licensed Nurses and Paramedics that were not working on [DATE] will be educated prior to their next shift. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Autumn Care of Waynesville		STREET ADDRESS, CITY, STATE, ZIP CODE: 360 Old Balsam Road, Waynesville, NC 28786	

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE] Director of Nursing or Designee educated all staff on effective communication between staff members during a Medical Emergency. The staff that were not working on [DATE] will be trained prior to their next shift. The Director of Nursing or Designee will ensure all staff that were not working on [DATE] will be educated prior to their next shift. On [DATE] the Director of Nursing or Designee educated all Licensed Nurses and Paramedics on observing and assessing residents for change of condition from baseline and communicating to provider for follow up and treatment in a timely manner. The Licensed Nurses and Paramedics that were not working on [DATE] will be educated prior to their next shift. The Director of Nursing or Designee will ensure Licensed Nurses and Paramedics that were not working on [DATE] will be educated prior to their next shift. On [DATE] the Director of Nursing or Designee educated all Licensed Nurses and Paramedics on recognizing serious decline of cognition and responsiveness of resident as an emergent occurrence and to contact provider and transfer to hospital immediately. The Director of Nursing or Designee will ensure Licensed Nurses and Paramedics that were not working on [DATE] will be educated prior to their next shift. On [DATE] Ad Hoc QAPI was completed regarding effective communication between staff in Medical Emergencies, timeliness of assessment, monitoring, and following provider orders to include transferring resident to hospital related to change of condition. On [DATE] the Regional Director of Clinical Services educated the Administrator, Director of Nursing, Assistant Director of Nursing, Scheduler and Human Resources on the orientation process that will include education on recognizing change of condition, effective communication during a Medical Emergency, timely assessment and monitoring, and assessment of change of condition including Blood Pressure, Pulse, Respirations, Temp, oxygen saturation, and Blood Sugar if resident is a Diabetic. The Director of Nursing or Designee will ensure newly hired Licensed Nurses or Paramedics receive education during Orientation on the Effective Communication during a Medical Emergency, timely assessment, monitoring, and assessment of change of condition including Blood Pressure, Pulse, Respirations, Temp, oxygen saturation and Blood Sugar if resident is a Diabetic. The Director of Nursing or Designee will ensure Agency Staff receive education on Effective Communication during a Medical Emergency, timely assessment, monitoring, and assessment of change of condition including Blood Pressure, Pulse, Respirations, Temp, oxygen saturation and Blood Sugar if resident is a Diabetic prior to first shift of working in facility. Alleged Date of Immediate Jeopardy removal: [DATE] (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE], the facility's plan for Immediate Jeopardy removal effective [DATE] was validated by the following: documentation and interviews with staff. Review of the audits for residents with a BIMS less than 12 revealed no issues. In-service sign-in sheets were reviewed with no issues found. Review of the training for Nurses and Nurse Aides (NAs) revealed both had been educated regarding prompt and timely monitoring and assessment of change of condition including blood pressure, pulse, temperature, respirations, oxygen saturation levels, and blood sugars. Education was also provided on documenting assessments and monitoring for change of condition, to include obtaining vital signs when a change in condition is noted, informing the provider in a timely manner of any change in condition, promptly following any orders given by the provider (including calling 911 and sending to the emergency room), and effective communication between staff during a medical emergency. Staff interviews were conducted, no staff had seen any change in the condition of their residents over the last 72 hours. The facility's Immediate Jeopardy removal date of [DATE] was confirmed. 2. Resident #282 was admitted to the facility after hospitalization on [DATE] (Friday) with diagnosis of diabetes. A review of Resident #282's hospital discharge orders dated [DATE] revealed an order for Humalog (quick acting insulin) Kwikpen subcutaneous, on a sliding scale (,d+[DATE]=4 units, ,d+[DATE]=6 units, , d+[DATE]=8 units, ,d+[DATE]=10 units, 350 and greater=12 units), to be administered before meals and at bedtime. The hospital discharge orders also revealed an order for insulin Glargine 23 units to be administered at bedtime daily. A review of the admission nursing assessment completed and dated [DATE] at 5:43 pm, revealed Resident #282 was documented as having been alert and oriented. Review of the facility's Laboratory Procedures standing orders, signed by the Medical Director on [DATE], revealed residents a history of diabetes blood sugars should be checked in the morning and at night for four days and nursing staff should notify the Medical Director (MD) with values and for further orders for blood sugars. There were no blood sugar results documented in Resident #282's medical record on [DATE], [DATE] or [DATE]. An interview was conducted on [DATE] at 1:19 pm with Nurse #5. Nurse #5 reported she worked second shift (2:30 pm to 10:30 pm) and was assigned to the 200-hall. She reported Resident #282 was admitted from the hospital on [DATE] during her shift and had only completed part of the admission assessment before she left. She reported she did not enter Resident #282's discharge orders from the hospital because that was usually done by the Assistant Director of Nursing (ADON), or the Director of Nursing (DON) and she believed the DON had already completed the orders. An order entered in the Electronic Health Record (EHR) by the DON dated [DATE] at 5:33 pm for Insulin Glargine (long-acting insulin) 23 units subcutaneous to be given at bedtime. There was no evidence of the Humalog Kwikpen order, or an order to check blood sugar levels, as written in the hospital discharge orders by the DON. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview was conducted on [DATE] at 10:55 am with Nurse #4. Nurse #4 reported she worked third shift on [DATE] (10:30 pm to 6:30 am) and was covering the 200 hall where Resident #282 resided. She reported that she had received a report from Nurse #5. Nurse #4 stated Nurse #5 had completed Resident #282's admission assessment but had not signed the assessment. She verbalized she had not verified the information charted was correct and had not verified Resident #282's hospital discharge orders with the orders in the facility's Electronic Medical Record (EMR) and signed her name to the assessment. She reported she was aware Resident #282 was a diabetic, but she had not checked her blood glucose level because it was a busy night. A review of the care plan dated [DATE] revealed Resident #282 was at risk for unstable blood sugars related to diabetes with a goal to remain free of symptoms and complications of hyperglycemia and hypoglycemia. Interventions included staff were to administer oral hypoglycemic [medications] and/or insulin [injectable medication] as directed by the physician, assess blood glucose levels as ordered and PRN [as needed], monitor labs as directed by the physician, monitor/educate resident for signs and symptoms of hyperglycemia (increased thirst, hunger, and increased urination), and monitor/educate for signs/symptoms of hypoglycemia (tachycardia, dizziness, sweating, headache, fatigue, and visual changes). According to the Medication Administration Record (MAR) for the month of [DATE], Resident #280 received Insulin Glargine 23 units at 8:00 pm on [DATE], [DATE], and [DATE]. The April MAR did not include the Humalog Kwikpen order or an order to check blood sugar levels. An interview was conducted on [DATE] at 9:12 am with Resident #282. Resident #282 reported around 12:00 am on [DATE] (Sunday night/Monday morning) she had told Nurse #3 that she was thirsty, felt like she could not get enough to drink, and was more tired than usual. She verbalized that she knew her blood sugar was high because it had gotten high before and had experienced those symptoms when her blood sugar was high in the past. Resident #282 reported the facility nursing staff had not checked her blood glucose level until [DATE] when she asked them to. A review of a nurse's note dated [DATE] at 12:46 am revealed Nurse #3 notified the on-call telehealth provider that Resident #282's blood sugar was 548. An interview was conducted on [DATE] at 4:41 pm with Nurse #3. Nurse #3 reported on [DATE] around midnight, Resident #282 kept asking for water and reported that she was thirsty. She reported Resident #282 had asked to have her blood glucose checked. Nurse #3 stated when she checked it, Resident #282's blood sugar was greater than 500 and she immediately notified the physician through their on-call electronic system and received orders to address the hyperglycemia and notify Resident #282's primary care provider (PCP) in the morning so that her medications could be reviewed. Nurse #3 reported there were no orders to check blood sugars until she notified the on-call electronic system [DATE]. A review of Resident #282's physician's orders dated [DATE] and timed 12:30 AM revealed the following: -Insulin Lispro (quick acting insulin) 10 units to be administered subcutaneously one time. -Blood glucose to be checked at 2:30 am and to report blood glucose level less than 70 and greater than 400 to a provider. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review of Resident #282's April MAR revealed the following: -Insulin Lispro 10 units was administered to Resident #282 on [DATE] at 12:30 am by Nurse #3. -Resident #282's blood glucose was checked at 2:30 am by Nurse #3 and was 355. A review of Resident #282's blood sugar checks revealed a blood sugar check was performed on [DATE] at 7:03 am at which time Resident #282's blood sugar was 274. An interview was conducted on [DATE] at 2:29 pm with the Director of Nursing (DON). The DON reported that she or the ADON did most of the orders for newly admitted residents. She reported the medication reconciliation was completed as soon as new residents arrived at the facility. The DON reported she entered the admission orders for Resident #282 on [DATE] at 5:33 pm and had overlooked that the resident was on sliding scale insulin at the hospital. She also reported that she forgot to enter an order for Resident #282's blood sugar to be checked. The DON stated that not having her blood sugars monitored and not receiving sliding scale insulin could have contributed to Resident #282 having a blood glucose of greater than 500 on [DATE]. An interview was conducted on [DATE] at 12:05 pm with the Nurse Practitioner (NP). The NP stated the admission nurse was responsible for entering the hospital discharge orders until she could assess the resident. She reported she worked at the facility on Mondays, Wednesdays, and Fridays, but she was not at the facility when Resident #282 was admitted . She was not aware the DON had not entered all of Resident #282's discharge orders from the hospital and verbalized she would have expected the DON to enter all the discharge medications until she could have seen the resident. She reported that not having scheduled sliding scale insulin and blood glucose checks could have contributed to Resident #282 having a blood sugar of greater than 500. An interview was conducted on [DATE] at 1:22 pm with the MD. The MD stated when a resident was newly admitted from the hospital that the medication reconciliation should be performed immediately. He stated the facility had standing orders to have blood sugar checked if a resident received insulin. The MD reported he was not aware Resident #282 had not had her blood glucose levels checked until [DATE] and would have expected her blood sugar to be checked the day she had arrived and to continue to check blood sugars as per the facility's Laboratory Procedures standing orders. He reported not receiving sliding scale insulin and not having her blood sugars checked, could have resulted in Resident #282's blood sugar being greater than 500. An interview was conducted on [DATE] at 9:22 am with the Administrator. The Administr [TRUNCATED]

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50045 Based on record review, family and staff interviews, the facility failed to prevent a pressure injury for a resident wearing a hinged knee brace. Resident #280 sustained an open pressure injury that became infected, had developed dead tissue, and wound treatments had not been completed. The deficient practice was identified for 1 of 2 residents (Resident #280) reviewed for pressure ulcers. The findings included: Review of the Orthopedic Progress note dated 1/5/2024 (prior to admission to the facility) revealed Resident #280 was treated nonoperatively for a right proximal tibia (bone in the lower leg) fracture and required a hinged knee brace locked in extension (leg straight) for her right leg. Resident #280 was admitted to the facility on [DATE] with diagnoses which included a fracture of the upper and lower end of the right fibula. A review of the physician's orders dated 1/11/2024 revealed Resident #280 was to always wear a hinged knee brace on her right leg for six weeks. A review of the care plan dated 1/12/2024 revealed Resident #280 was at risk for skin breakdown due to fragile skin, impaired mobility, muscle weakness, decreased safety awareness, and incontinence with goals and interventions which included completing skin checks per protocol, and to monitor/document/report any changes in color/temperature/sensation/pain/drainage/odor to the Physician. A review of an Occupation Therapy Evaluation and Treatment Plan dated 1/12/2024 revealed Resident #280 wore an immobilizer on her right lower extremity. Further review of the documentation revealed there were no skin assessments of the right lower extremity completed. An admission Minimum Data Set (MDS) dated [DATE] revealed Resident #280 was cognitively intact, had not exhibited any behaviors, and was not documented as having any wounds. A wound assessment completed by Paramedic #2 (employed by the facility, functioning as the Wound Care Nurse) dated 1/30/2024 revealed Resident #280 had a right posterior calf abrasion (scrape) where the hinged knee brace was located. The wound was documented as being 5.0 centimeters (cm) in length, 2.0 cm in width, and 0.1 cm in depth. The wound was documented as a new wound, facility acquired, with a pink wound bed, scant (very small) amount of serosanguineous (yellow and bloody in color) drainage, with no odor, and the physician was notified by Paramedic #2 on 1/30/2024 at 4:00 pm. Orders were received at that time to clean the wound, apply triple antibiotic ointment, to apply an island dressing (breathable, non-sticking dressing), and to change the dressing every Monday, Wednesday, and Friday or as needed until the wound was healed. Wound care documentation provided by Paramedic #2 revealed wound care had been performed on 1/30/2024. No documentation was provided for 1/31/2024 (Wednesday), 2/2/2024 (Friday), 2/5/2024 (Monday), and 2/7/2024 (Wednesday). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A wound assessment dated [DATE] revealed Resident #280's right posterior calf wound measured 7.5 cm in length, 7.5 cm in width, and 0.3 cm in depth. The wound was documented as having a moderate amount of serous (yellow-colored fluid) drainage, a pink wound bed, and no wound odor. Orders were received at that time to clean the wound, pat the wound dry, apply Calcium Alginate (wound dressing to treat draining wounds) to the wound bed, to cover with foam dressing, and to change the dressing every Monday, Wednesday, and Friday or as needed until the wound was healed. Wound care documentation provided by Paramedic #2 revealed wound care had been performed on 2/8/2024. No documentation was provided for 2/9/2023 (Friday), 2/12/2024 (Monday) and 2/14/2024 (Wednesday). A wound assessment dated [DATE] revealed Resident #280's right posterior calf wound measured 7.5 cm in length, 7.6 cm in width, and 0.4 cm in depth. The wound was documented as having moderate serous drainage with a black wound bed and a faint wound odor. The physician was notified by Paramedic #2 on 2/14/2024 at 10:00 am and orders were received for the wound to be cleaned, patted dry, to apply Half Strength Dakin's (diluted bleach solution)-soaked gauze, to cover with an abdominal dressing, and wrap in gauze. Wound care documentation provided by Paramedic #2 revealed wound care had been performed on 2/15/2024. No documentation was provided for 2/16/2024 (Friday), 2/19/2024 (Monday), and 2/21/2024 (Wednesday). A wound assessment dated [DATE] revealed Resident #280's right posterior calf wound measured 7.1 cm in length, 6.5 cm in width, and 0.4 cm in depth. The wound was documented as having moderate serous drainage with a pink wound bed. No peri wound assessment was documented. Wound care documentation provided by Paramedic #2 revealed wound care had been performed on 2/22/2024. No documentation was provided for 2/23/2024 (Friday) and 2/26/2024 (Monday). Resident #280 was no longer at the facility; therefore, no observation of the wound was able to be made. An interview was conducted on 4/29/2024 at 9:55 am with Paramedic #2. Paramedic #2 reported Resident #280 was ordered to wear a knee brace on her right leg. She reported on 1/30/2024 she had removed the knee brace to assess Resident #280's skin, after Resident #280 had verbalized she thought the brace was rubbing her right leg and she was having pain. When Paramedic #2 removed the knee brace, she realized the brace had rubbed against the back of Resident #280's right leg and verbalized the knee brace was not padded. Paramedic #2 reported the new abrasion to the provider and had the Physical Therapy Director pad the brace to prevent further rubbing of the skin. Paramedic #2 reported the right posterior leg wound continued to get worse and she assessed the skin underneath the brace when she performed Resident #280's wound care. Paramedic #2 did not comment on why she had not consistently performed wound care for Resident #280. An interview was conducted on 5/2/2024 at 12:11 pm with the NP. The NP reported Paramedic #2 had notified her Resident #280's wounds were not healing on 2/9/2024. The NP was not aware Resident #280's brace had not been padded on admission. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted on 5/3/2024 at 9:19 am with the Physical Therapy Director. The Physical Therapy Director reported he was asked by Paramedic #2 to pad Resident #280's knee brace. The Physical Therapy Director stated Occupation Therapy (OT) looked at knee braces when a resident was admitted and if there was any indication the brace would rub/had rubbed the skin, the brace would be padded at that time. The Physical Therapy Director was unable to provide documentation where OT had evaluated the brace upon Resident #280's admission to the facility. An interview was conducted on 5/3/2024 at 8:50 am with the Director of Nursing (DON). The DON was not aware Resident #280 had sustained a pressure injury from her hinged knee brace and had no further comments. An interview was conducted on 5/3/2024 at 9:33 am with the Administrator. The Administrator was not aware Resident #280 had sustained a pressure injury from her hinged knee brace. He had no comments related to Resident #280's injury.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50045 Based on record reviews, family member, staff, resident, and lift company representative interviews the facility failed to prevent injury when transferring a resident (Resident #280) from a wheelchair to the bed causing a laceration to the resident's left lower leg which required a transfer to the emergency department and treatment of the laceration with sutures. The facility failed to provide a safe transfer when they did not use a mechanical sit-to-stand lift in accordance with manufacturer instructions to transfer a resident (Resident #60). This deficient practice occurred for 2 of 3 residents (Resident #280 and Resident #60) reviewed for accidents and hazards. The findings included: 1. Resident #280 was admitted to the facility on [DATE] with diagnoses which included a fracture of the upper and lower end of the right fibula (bone in the lower leg). A review of the care plan dated 1/12/2024 revealed Resident #280 was at risk for skin breakdown due to fragile skin, impaired mobility, muscle weakness, decreased safety awareness, and incontinence with goals and interventions which included avoiding mechanical trauma. An admission Minimum Data Set (MDS) dated [DATE] revealed Resident #280 was cognitively intact and had not exhibited any behaviors. An interview was conducted on 4/29/2024 at 10:09 am with Physical Therapy Assistant (PTA) #1. PTA #1 reported she worked with Resident #280 on 1/22/2024 and she and PTA #2 were transferring Resident #280 from her wheelchair to the bed. PTA #1 reported that she and PTA #2 stood Resident #280 up and pushed the wheelchair back. PTA #1 reported Resident #280 did a stand pivot transfer to the side of the bed and sat down. PTA #1 then observed a drop of blood on the back of Resident #280's left leg and an area of open skin approximately 1 inch in length. PTA #1 reported Nurse #6 was called to the room and took over from there. PTA #1 reported she had not observed anything sharp on Resident #280's wheelchair or her bed. An interview was conducted on 5/2/2024 at 11:41 am with PTA #2. PTA #2 reported she worked with Resident #280 on 1/22/2024. She reported that she and PTA #1 were transferring Resident #280 from her wheelchair to the bed. PTA #2 reported Resident #280 stepped with her left leg towards the bed and then Resident #280 stepped back with her right leg towards the bed. PTA #2 stated Resident #280's nose began to bleed, and she saw blood on the ground. PTA #2 stated when she looked at the floor, she saw a lot of blood on the back of Resident #280's left leg and observed a jagged wound approximately 2 inches long. PTA #2 reported she immediately applied pressure to the wound and got Nurse #6. PTA #2 reported Resident #280 was taken to the emergency room and Resident #280's wheelchair was never taken out of service. PTA #2 reported she had not observed anything sharp on Resident #280's wheelchair or her bed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A telephone interview was conducted on 5/2/2024 at 3:46 pm with Resident #280's Family Member #1. Family Member #1 reported Family Member #2 was in the room on 1/22/2024 with Resident #280 when therapy transferred her from the wheelchair to the bed. Family Member #1 reported Family Member #2 witnessed a large screw sticking out from the left front leg of the wheelchair and that the screw had snagged Resident #280's skin when the Physical Therapy Assistants had transferred Resident #280 from her wheelchair to her bed. Family Member #1 was unsure if the wheelchair had been taken out of service and verified there was no padding on the wheelchair legs until after the incident on 1/22/2024. Family Member #1 reported she had not noticed the screw sticking out of Resident #280's wheelchair prior to 1/22/2024. A telephone interview was conducted on 5/8/2024 at 11:21 am with Family Member #2. Family Member #2 reported she was in the room on 1/22/2024 with Resident #280 was transferred from her wheelchair to the bed and sustained a laceration. Family Member #2 reported PTA #1 and PTA #2 had helped Resident #280 to stand, and one of the Physical Therapy Assistants had jerked the wheelchair back at which time her leg caught a screw/bolt on the left leg of the wheelchair and snagged her left leg. The Physical Therapy Assistants continued to pivot Resident #280 to the bed and realized the back of Resident #280's left leg was bleeding. Family Member #2 reported the wound was in a V shape and approximately 2 inches on both sides. She reported Resident #280's pajama pants were saturated with blood and had to be thrown away. Family Member #2 reported her concern about the screw/bolt on the wheelchair to PTA #1 and PTA #2 and was told by PTA #1 and PTA #2 there was no way the screw/bolt could have cut Resident #280's left leg. Review of a nursing note written by Nurse #6 dated 1/22/2024 at 4:16 pm revealed she was called to Resident #280's room and observed a large laceration with fatty tissue exposed on the left lateral calf. She documented Resident #280 was being transferred from the wheelchair to the bed with two people assisting her. Nurse #6 further documented pressure was applied to the wound and wheelchair leg rests/connector had sharp metal but there were no exposed jagged edges. An interview was conducted on 5/2/2024 at 2:33 pm with Nurse #6. Nurse #6 reported she was called to Resident #280's room by Physical Therapy Assistant (PTA) #1 and PTA #2 on 1/22/2024 after Resident #280 sustained a laceration to her left lower leg during a transfer from the wheelchair to the bed. Nurse #6 recalled a pretty large wound and reported the wound was full thickness with tissue exposed. She reported it was unclear what it was hit on. She reported that someone had come and taken the wheelchair out of service after Resident #280 was taken to the hospital. She reported there was sharp metal on the legs of the wheelchair itself. She reported the legs of the wheelchair had been removed prior to her arriving. Review of the Emergency Medical Services documentation dated 1/22/2024 at 3:50 pm revealed Resident #280 was found sitting on the side of the bed with a laceration about 8 inches long on her left calf area and bleeding had been controlled by nursing home staff. Documentation further revealed the laceration was from blunt force trauma by a sharp object. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the emergency room (ER) note dated 1/22/2024 at 5:50 pm revealed Resident #280 arrived at the emergency room via Emergency Medical Services (EMS) and was transferring from her wheelchair to the bed when she sustained a laceration to the lateral aspect of the left lower leg. Documentation further revealed Resident #280 reported she believed she leg was caught due to an exposed metal edge. Wound documentation revealed a lengthy laceration to the lateral left lower leg measuring roughly 10 centimeters with exposed adipose tissue. The emergency room Physician ordered for Resident #280 to receive a tetanus vaccine in the emergency room , for the facility to keep the area clean and dry, change dressings routinely, clean the area with soap and water, apply antibiotic ointment with dressing changes, and to remove sutures in two weeks. The number of sutures was not included in the ER note. An interview was conducted on 5/3/2024 at 9:17 am with the Physical Therapy Director. The Physical Therapy Director reported he was aware of the incident that occurred on 1/22/2024 when Resident #280 was being transferred from the wheelchair to the bed. He reported the wheelchair was not taken out of service but that he did pad the wheelchair legs after the incident. He reported that he was not able to recall any sharp metal or screws sticking out of Resident #280's wheelchair and he was not able to determine what Resident #280 had been cut on. The Physical Therapy Director verified the wheelchair Resident #280 used belonged to the facility. An interview was conducted on 4/29/2024 at 3:48 pm with the Maintenance Director. The Maintenance Director reported facility staff were responsible for letting him know if any equipment or devices were broken by writing it down in the maintenance book located at each of the nurse's stations. The Maintenance Director reported he checked the maintenance book every morning when he arrived at the facility. He reported he did not save his maintenance logs or the forms that had been placed in the maintenance book because he was not aware that he needed to do so. He reported he was not able to recall Resident #280's wheelchair being taken out of service or brought to him for padding. He reported he relied on facility staff to report issues. An interview was conducted on 5/3/2024 at 8:50 am with the Director of Nursing (DON). The DON reported she was aware of a wound Resident #280 sustained when she was transferred from the wheelchair to the bed with Physical Therapy on 1/22/2024. The DON stated she was aware there was a laceration to the back of Resident #280's left leg and reported after the laceration occurred, the Physical Therapy Director had taken the wheelchair out of service to pad it and then returned it back to Resident #280's room. The DON reported she had not looked at the wheelchair after the incident and was unsure what Resident #280 cut her left leg on. 50046 2. Review of the facility's sit-to-stand lift manufacturer manual Operating and Product Care Instructions dated June 2003, read in part: Unauthorized modifications on the equipment may affect its safety and are in breach of any equipment warranty. The manufacturer will not be held responsible for any accidents or incidents or lack of performance that occur because of any unauthorized modifications. Lower leg straps: Pass around the knee supports, then around the patients lower calve. Ensure that the straps are firm but comfortable. Push the lift in close to make full lower leg contact with the knee support. Maximum lifting capacities: Basic lift 350 pounds (lbs.). All Slings 350 lbs. Resident #60 was readmitted to the facility on [DATE] with diagnoses including morbid (severe) obesity. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #60's electronic medical records revealed a weight recorded on 4/4/24 of 340.8 lbs. Review of Resident #60's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed she was cognitively intact and was dependent on transfers. Review of Resident #60's care plan revised 4/14/24 revealed she had self-care deficit related to complications due to decreased mobility. The intervention was to transfer with the sit to stand lift with 2 staff assisting for safe transfer into the wheelchair from the bed. An interview was conducted on 4/29/24 at 8:45 AM with Resident #60. She said she had used the sit-to-stand lift for a month. The knee brace molds on the sit-to-stand lift did not fit her legs. She said therapy had added padding to the lift knee brace using pillows to help make it more comfortable. An interview was conducted on 4/30/24 at 11:01 AM with the Director of Rehabilitation. He said that Resident #60's lower legs did not fit into the sit-to stand lift knee brace molds and that the brace edge hit along the outside of her legs. He stated he had used pillows for padding the front of the knee brace and the leg safety straps were fastened when the pillows were positioned. The Rehab Director said that during the morning stand up meeting different lift options were discussed with the Administrator. He stated they decided to use the lift they had and pad it. An observation was conducted on 4/30/24 at 2:15 PM with the Rehabilitation Director while Resident #60 was transferred with the sit-to stand lift. The observation revealed Resident #60's lower legs, knees and shins were too large to fit into the knee brace molds of the lift. The knees and shins extended over the edge of the knee brace by 3 inches on each side. The Director of Rehabilitation tucked a pillow between Resident #60's knees and the lift knee brace after the leg safety strap was fastened. An interview was conducted on 5/1/24 at 2:36 PM with the Quality Assurance (QA) nurse. She said the sit-stand-lift could not be altered in any way and that adding pillows to the knee brace for padding altered the lift. She stated it had been discussed during the morning meeting that the pillows caused the safety leg straps on the lift to not fasten correctly. The purpose of the knee brace was to keep a resident's knees from buckling during a transfer. If the legs did not fit into the knee brace molds or leg straps were loose, then the legs could buckle and cause injury. An interview was conducted on 5/1/24 at 3:33 PM with the DON. She stated therapy had wanted to alter the knee brace of the sit-to-stand lift and the safety leg straps by putting pillows between the resident and the knee brace and leaving the leg safety straps loose. She had told the nursing staff not to do that or alter the lift when transferring. She stated the sit-stand-lift was not safe for Resident #60 to use if it was altered with pillows. An interview was conducted on 5/2/24 at 8:51 AM with Physical Therapy Assistant (PTA) #3. She said Resident #60 had discomfort using the sit-to-stand lift because her legs did not fit the knee brace and that pillows were used to pad the knee brace to relieve the discomfort. She stated she was concerned that adding pillows was altering the lift and using a lift that had been altered was unsafe. PTA #3 stated the pillows could cause her knees to buckle during a lift transfer. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	An interview was performed on 05/02/24 at 9:18 with Nurse Aide (NA) #2. She stated the Director of Rehab had told her to use pillows to pad the sit- to- stand lift. She stated that they put pillows in between Resident #60's knees and the knee brace of the sit-stand-lift when they transferred her. She said the leg safety straps did not fasten if the pillows were placed first. She said nursing management never told her that pillows were not to be used. An interview was conducted on 5/2/24 at 10:53 AM with the Administrator. He said the total mechanical lift was used to transfer Resident #60, but that she had requested to use the sit-to-stand lift instead to work on therapy goals of standing and walking. He stated he was aware Resident #60 was unable to use the sit-to-stand lift comfortably because her legs did not fit the knee brace. The Administrator said the Rehabilitation Director told him the current sit-to-stand lift was appropriate and that he could use pillows to pad the knee brace edges. The Administrator stated the leg safety straps were not long enough to go around Resident #60's legs and the pillows. He said the nursing staff was instructed not to use pillows to pad the knee brace of the sit-to-stand lift to transfer Resident #60 and not to alter the sit-to-stand lift by the DON. He was not aware that therapy used pillows or altered the sit-to-stand lift. A telephone interview was conducted on 5/7/24 at 2:53 PM with the sit to stand lift company representative. He reviewed the instruction manual for using the sit-to-stand lift and he did not recommend any pillows or additives be used and stated that inserting pillows altered the lift. The Representative stated pillows or any other additive could 100% jeopardize the safety of the lift and increase the risk of an accident. He discussed the purpose of the sit-stand-lift knee brace was to keep the resident's knees from buckling while they were in the lift. He said it was not safe to put a resident in a standing position on the sit-to-stand lift without a knee brace directly against the resident's lower extremities.

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F 0895 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a Compliance and Ethics Program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50045 Based on record review, Resident, former staff, Corporate Human Resources Representative and current staff interviews, the Governing Body or its designated person failed to have the Business Office Manager sign a Duty to Disclose Conflict of Interest form and approve or deny a plan to purchase property from a resident for 1 of 1 resident (Resident #8) reviewed for compliance and ethics policy implementation. The findings included: A review of the facility's Ethical Business Practices and Conflicts of Interest policy effective April 2015 (last revised 1/18/2024) stated employees are expected to conduct themselves to avoid actual impropriety and/or the appearance of impropriety in making business decisions. Employees may not use their positions to profit personally or to assist others in profiting in any way at the expense of the Corporate Office or its residents. Employees shall disclose to their supervisor and to the Compliance Department any financial interest, ownership interest, or any other relationship they have with Corporate Office's residents, vendors, or competitors. The policy further states facility employees have a duty to disclose in connection with any transaction or arrangement, which may create an actual or possible conflict of interest, an interested person shall disclose in writing the existence and nature of his/her financial interest and all material facts. The policy further states all other employees shall make such disclosures to their supervisors. Resident #8 was admitted to the facility on [DATE] with diagnoses of depression and generalized anxiety disorder. A quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #8 was cognitively intact and had not exhibited any behaviors. An interview was conducted on 4/29/2024 at 12:04 pm with Former Nurse Aide (NA) #1. Former NA #1 reported Resident #8 had told her in May of 2023 the Business Office Manager had approached her and told her that her property was in foreclosure. Former NA #1 reported Resident #8 told her the Business Office Manager lined up attorneys and the process was very quick. Former NA #1 stated she reported her concerns about the Business Office Manager purchasing land from Resident #8 to the Corporate Human Resources Representative and never got any response. Former NA #1 verbalized she was concerned Resident #8 had been taken advantage of and was not provided all the information needed to make an informed decision. Former NA #1 stated she had spoken with the Former Administrator, and he had advised her to contact the State. (continued on next page)

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F 0895 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 4/29/2024 at 12:19 pm with Resident #8. Resident #8 reported she had sold a double wide, an old house with no electricity, and a portion of land (approximately 0.8 acres) in May of 2023. Resident #8 stated her family member had notified her that a letter had been mailed to the family member that her property was in foreclosure. Resident #8 stated the Business Office Manager overheard the conversation she had with her family member and approached her about purchasing the land. She reported she did not have an advocate during the process, but that the property was appraised prior to it being sold and she was not able to recall how much money the property sold for. Resident #8 reported she left the faciity on the day of the sale to go to the Business Office Manager's attorney's office and the courthouse. Resident #8 stated she had not made any profit on the sale, she did not have any outstanding bills at the facility, and she sold the property strictly to get it out of foreclosure so it would not affect her family member's credit. An interview was attempted with Resident #8's family member on 4/29/2024 at 2:58 pm. Resident #8's family member never returned the phone call. An interview was conducted on 4/29/2024 at 2:23 pm with the Business Office Manager. The Business Office Manager reported Resident #8 had active Medicaid and believed Resident #8 had some property sell in 2023. The Business Office Manager reported the property did not sell for much, approximately $50,000, and Resident #8 owed approximately $30,000 on the property. The Business Office Manager stated it had not taken long for Resident #8 to spend the profit down and that Resident #8's current trust balance was $87.80. The Business Office Manager stated Resident #8 had approached her about the property being in foreclosure. The Business Office Manager reported she told her spouse about the property, and her spouse approached Resident #8's family member. The Business Office Manager stated she and her spouse purchased the property in May of 2023, paid cash to the attorney, the attorney paid off the mortgage and left over taxes, and the remaining money split between Resident #8 and her family member. The Business Office Manager stated Resident #8 had declined legal counsel. The Business Office Manager also was not able to recall speaking with anyone at corporate about a conflict of interest prior to the purchase of Resident #8's property. An interview was conducted on 4/30/2024 at 1:02 pm with the Former Administrator. The Former Administrator verbalized he had worked at the facility for [AGE] years prior to leaving at the end of May of 2023. He reported he was aware of the Business Office Manager approaching many of her neighbors to try to expand her property. The Former Administrator verbalized he knew at one point the Business Office Manager had reached out to Resident #8's family member about purchasing property. The Former Administrator was not aware of the property being in foreclosure and voiced he had not recalled receiving any communication from the Business Office Manager regarding a possible conflict of interest, as outlined in the facility's policy. The Former Administrator further stated he was unaware that the Business Office Manager had gone through with the purchase of the property in May of 2023. An interview was conducted on 4/29/2024 at 2:38 pm with the Current Administrator. The Current Administrator reported he was not aware of any real estate transaction between the Business Office Manager and Resident #8's property. He reported the facility does training on ethics. The Current Administrator verbalized the sale had to be straight forward. He also reported the facility had policies regarding conflict of interest. (continued on next page)

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F 0895 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 4/29/2024 at 3:02 pm with the Register of Deeds. The Register of Deeds reported she could not see where the property was in foreclosure, only a Substitution of Trustee. The Register of Deeds verified with tax records that Resident #8's property went to the Business Office Manager and her spouse on 5/4/2023. Review of the North Carolina General Warranty Deed dated 5/3/2023 revealed the signatures of Resident #8 along with two other individuals, in addition to the Business Office Manager's signature along with her spouse's. An interview was conducted on 4/30/2024 at 1:26 pm with the Corporate Human Resources Official. The Corporate Human Resources Official reported staff should not be purchasing property from any resident and verbalized there was a policy in place pertaining to a duty to disclose any conflicts of interest. The Corporate Human Resources Official reported the Business Office Manager had not submitted any conflict-of-interest documentation and she was not aware the Business Office Manager had purchased property from Resident #8.