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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50046 Based on record reviews, staff, resident, and lift company representative interviews the facility failed to accommodate the needs of a bariatric resident who needed a mechanical sit-to-stand lift with a larger knee brace for transfers for 1 of 1 resident (Resident #60) reviewed for accommodation of needs. The findings included: Resident #60 was readmitted to the facility on [DATE] with diagnoses including morbid (severe) obesity and a history of nontraumatic intracranial hemorrhage (bleeding in the brain). 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 for 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 and observation 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. The edges of the knee brace dug into the edges of her lower legs along her shins and her knees, and it hurt. She stated the discomfort was 4 out of 10 to her knees and shins during transfers using the sit-to-stand lift. An observation of the leg, knees and skin revealed no visible marks or bruising. She said therapy had added padding to the lift knee brace using pillows. She stated the pillows helped, but that there was still discomfort. Resident #60 said the Administrator, the Director of Nursing (DON), and therapy had spoken with her about the lift and were aware the lift hurt her legs. She stated the Administrator told her they would rent a bariatric sit-to-stand lift. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 4/30/24 at 11:01 AM with the Director of Rehabilitation. He said he was aware that the sit-to-stand lift was uncomfortable and that it hurt Resident #60's legs and shins. He said that her lower legs did not fit into the knee brace molds and that the brace edge hit along the outside of her legs. He had used pillows for padding the front of the knee brace and the leg safety straps were fastened when the pillows were positioned. He stated that even with the padding Resident #60 complained of pain. During the morning stand up meeting renting a bariatric lift had been discussed with the Administrator. They decided to use the lift they had and pad it. He did not know the plan to obtain the correct sized sit-to-stand lift. An observation and interview 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 after the leg safety strap was fastened. She complained her discomfort was 3 out 10 level along her shins and legs. An interview was conducted on 05/01/24 at 8:23 AM with the Maintenance Director. He stated the Administrator had asked him to contact the lift supply company about a month ago to ask about renting a wider or bariatric sit-stand-lift. The lift supply company did not rent bariatric lifts, they sold them. The information was given to the Administrator. He stated he had not reached out to any other medical equipment retailers to enquire if they rented bariatric lifts. An interview was conducted on 5/1/24 at 2:36 PM with the Quality Assurance (QA) nurse. She said the sit-stand-lift 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. She stated Resident #60 needed a bariatric sit-to stand lift for her legs to fit into the knee brace. She stated renting a bariatric lift had been discussed in the morning meeting but that she did not know about the decision. 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. The facility needed to purchase a bariatric sit-to-stand lift. She said the total mechanical lift should be used until then. An interview was conducted on 5/2/24 at 8:51 AM with Physical Therapy Assistant (PTA) #3. She stated Resident #60 complained of pain when she used the sit- to- stand lift from the knee brace on her legs. Pillows were used to relieve the discomfort. She was concerned that adding pillows was altering the lift and using a lift that had been altered was unsafe. The pillows could cause her knees to buckle during a lift transfer. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for 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 because 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 stated he was aware Resident #60 was unable to use the sit-to- stand lift comfortably. 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. The facility had looked into renting a bariatric lift which was unsuccessful. Then they looked at purchasing a bariatric sit-stand-lift. The Rehabilitation Director stated the current sit-to-stand lift was appropriate and to use pillows to pad the edges. The leg safety straps were not long enough to go around Resident #60's legs and the pillows. 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. 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 stated the facility's sit-to-stand lift had an older knee brace mold model.The newer model had a silicone flex knee brace pad, and it was more flexible and comfortable and would fit a larger range of residents. 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. Pillows or any other additive could 100% jeopardize the safety of the lift and increase the risk of an accident. 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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49366 Based on record reviews and interviews with family members, resident, and staff, the facility failed to provide a resident with a written notice of a room change including the reason for the change for 1 of 1 resident reviewed for room change (Resident #230). The right to receive written notice, including the reason for the change, before the resident ' s room or roommate in the facility is changed. The findings included: Resident #230 was admitted to the facility on [DATE] with diagnoses to include acute gastric ulcer with perforation, major depressive disorder, and hypertension. The 5-day Minimum Data Set (MDS) assessment dated [DATE] Resident #230 was moderately cognitively impaired. Resident #230 resided in room [ROOM NUMBER] on 4/28/24 and was moved to room [ROOM NUMBER] on the morning of 4/29/24. Record review of the electronic health record on revealed there was no written documentation of a notice of a room change, or progress note that recorded notification of a room change. An interview with Resident #230 on 4/29/24 at 12:32 PM revealed an unknown staff person stood at the foot of her bed earlier in the morning and told her she was to be moved to a new room because a man needed room [ROOM NUMBER]. Resident #230 stated she was very upset as she had no notice of the move, and the abrupt room change was traumatizing she was never shown the new room prior to the move. She called Family Member #1 who then came to the facility. In an interview on 4/30/24 12:36 PM, the Social Worker (SW) stated she always contacted the family if there was a room change. She explained the notice was verbal only. There was no written notification. The housekeeping supervisor received a room change notification and moved the resident. She stated she verbally informed Family Member #2 on the morning of 4/29/24. A telephone interview with Family Member #2 on 4/30/24 at 12:56 PM revealed she was not at the facility and nor was she informed of the move. She had not received a written or verbal notice of a room change. Family Member #2 was not able to comment on Resident #230's mental state. A telephone interview on 4/30/24 at 1:01 PM with Family Member #1 revealed he received a call from Resident #230 on 4/29/24 upset she was moved from her room. He immediately came to the facility. The Admissions Director told him that because the bathroom was shared with a male next door the room was for a male resident. Family Member #1 was not able to comment on Resident #230's mental state but noted he was upset about the way Resident #230 was abruptly notified. (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 4/30/24 at 1:07 PM, the Admissions Director stated Resident #230 shared a bathroom with a male resident for three days and needed to be moved. She stated she called and left a message for Family Member #1. She explained that they did not provide written notices to residents or family members for any internal room changes but a progress note was written for each room change. An interview with the Director of Nursing (DON) on 5/2/24 at 10:05 AM revealed the SW called families and documented any room change. She explained room changes were often completed within the same day. An interview with the Administrator on 5/2/24 at 10:05 AM revealed the SW was responsible for the documentation for all room changes in the resident's progress notes.

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 49366 Based on observations, resident and staff interviews, the facility failed to display survey results in a location accessible to residents during 5 of 5 observations of the facility. The findings included: During a tour of the facility on 4/28/24 at 11:45 AM, the survey results were not observed in the common areas of the building. An observation of the front lobby revealed a small table on the right side of the lobby under a television screen which showed announcements and infection control information. There was nothing on top of the table. Tours of the facility on 4/29/24 at 11:01 AM, 4/30/24 at 3:10 PM, and 5/1/24 at 1:29 PM and 5/2/24 at 9:59 AM revealed the survey results were not located in the common area accessible to the residents or in any other accessible location in the facility. A Resident Council group meeting was conducted on 5/1/24 at 1:00 PM. During the meeting, the residents indicated the survey results used to be in a blue notebook in the front lobby on a small table. An interview with the Director of Nursing (DON) on 5/2/24 at 10:01 AM revealed the blue notebook was in the lobby on a table for visitors and residents. An observation and interview with the Administrator on 5/2/24 at 10:05 AM in the lobby revealed the blue notebook was not there. Returning to the receptionist's office, the survey results were on a bookshelf. The Administrator stated the bookshelf was moved from the front lobby to the Receptionist's office and it was an oversight.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50045 Based on record review and staff interviews the facility failed to accurately document the resident's code status on the Medical Orders for Scope of Treatment (MOST) form. The facility also failed to provide Emergency Medical Services (EMS) a copy of a resident's advanced directive when she was transferred to the emergency room after being found unresponsive for 2 of 2 residents reviewed for advanced directives (Resident #12 and #280). The findings included: 1) Resident #12 was admitted to the facility on [DATE]. A review of the physician's orders revealed a Do Not Resuscitate order for Resident #12 dated 10/6/2023 and signed by the Medical Director (MD). A review of a care plan dated 3/16/2024 revealed Resident #12 had chosen to be a Do Not Resuscitate (no chest compressions). A quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #12 was cognitively intact with no behaviors. A review of the facility's advance directives book at the nurse's station revealed Resident #12 had a golden Do Not Resuscitate form, dated 1/15/2024 with no expiration date, in addition to a MOST form, with an effective date of 1/24/2024, which indicated Resident #12 was a full code with comfort measures and was signed by the Nurse Practitioner and Resident #12 on 1/15/2024. An interview was conducted on 4/30/2024 at 10:03 am with Nurse #2. Nurse #2 reported advanced directive forms were usually completed by the Social Worker (SW). Nurse #2 reported she did not have any part in the advanced directive process unless a resident had expressed, they wanted to change their wishes to her. Nurse #2 stated advanced directives were kept in the advanced directive book at the nurse's station, a physician's order was in the chart, and code status was also visible on the Electronic Health Record (EHR) banner. An interview was conducted on 4/30/2024 at 10:12 am with the SW. The SW stated she discussed code status with residents and their families on admission. She reported she asked residents if they would want chest compressions and if they did not want chest compressions, she would complete a DNR and a Medical Orders for Scope of Treatment (MOST) form. She reported she would then give the form to the QA Nurse to get the MD or Nurse Practitioner (NP) to sign it. The SW confirmed that code status information on the DNR should be reflected on the MOST form. The SW verified a DNR had been completed on 1/15/2024 for Resident #12, and the MOST form dated 1/24/2024 indicated Resident #12 was a full code. She reported she had made a mistake on the form that they should both indicate DNR. The SW stated she does not document anywhere in the medical record that the resident or family had been educated regarding advanced directives because she did not know that was required. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 5/2/2024 at 12:08 pm with the NP. The NP reported the SW reviews and answers questions regarding the MOST form and DNR with the resident and their family. The NP stated she only signs the form and did not verify to ensure that the DNR sheet and the MOST form matched. The NP reported she was not aware Resident #12's MOST form and DNR did not match and reported they should reflect DNR wishes. An interview was conducted 5/3/2024 at 8:41 am with the Director of Nursing (DON). The DON reported that when a resident is admitted to the facility she will assess to see if there were any advanced directives in place and enter the code status order in the Electronic Health Record (EHR). The DON stated the SW and medical team went over code status with the family of Resident #12 upon admission. At that time the SW and medical team completed a DNR or MOST form. She reported the MOST form should reflect a DNR and state no chest compressions. She was not aware Resident #12's MOST form indicated she was a full code and that a DNR was in place. She verbalized the MOST form should have reflected do not resuscitate. 2) 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 physician's orders dated 1/11/2024 revealed an order for Do Not Resuscitate (DNR). Review of the care plan dated 1/12/2024 revealed Resident #280 was a Do Not Resuscitate (DNR) with goals and interventions which included Resident #280's wishes would be followed and advanced directives should be documented. 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. Review of the Emergency Medical Services (EMS) assessment dated [DATE] at 9:03 pm revealed nursing home staff were not able to find Resident #282's DNR and that they had lost the paperwork for this. Advance directives were documented on EMS assessment as none. Documentation further revealed Resident #280 was found to be unresponsive and was transferred out of the facility at 8:13 pm to the emergency room . A review of Resident #280's Electronic Medical Record (EHR) was conducted on 4/28/2024 and revealed no scanned DNR form. An interview was conducted on 5/8/2024 at 4:09 pm with Paramedic #1. Paramedic #1 reported he was assigned Resident #280 on 3/5/2024 at which time she was transferred via EMS to the hospital. Paramedic #1 stated EMS had asked him for Resident #280's DNR and that he was not able to find her DNR form in the book at the nurse's station. He reported if Resident #280 would have been found without a pulse, he would have had to perform chest compressions because the form was gone. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 4/30/2024 at 10:12 am with the Social Worker (SW). The SW reported she spoke with residents and their family about code status and advanced directives during their initial assessment. She reported she asked the resident if they wanted chest compressions and if the resident did not want chest compressions, she completed a DNR form. She reported after she completed the DNR form, she gave the form to the QA Nurse, the QA Nurse would get the MD to sign the form. The SW reported if a resident was transferred to the hospital, the facility should provide EMS with any advanced directives. She was not aware if a DNR form had been completed for Resident #280 and had not been made aware that EMS had not been provided with a copy of Resident #280's advanced directives. An interview was conducted on 5/2/2024 at 10:36 am with the Medical Records Coordinator. She stated once an advanced directive was completed, the Quality Assurance (QA) Nurse or the Social Worker (SW) were supposed to bring her the form for her to scan into the EHR and place the original forms in the book at the appropriate nurse's station. The Medical Records Coordinator reported she had not received any advanced directive forms since December 2023 and had expressed concerns about not receiving advanced directives to the Director of Nursing (DON) and Administrator and reported nothing had changed. The Medical Records Coordinator stated she did not have a copy of Resident #280's DNR form. She reported if the QA Nurse or SW would have given her a DNR form, it would have been scanned into the EHR. She verified Resident #280's advanced directive form was not in the advanced directive book at either of the two nurse's stations. An interview was conducted on 5/2/2024 at 11:05 am with the QA Nurse. The QA Nurse reported the hall nurses were responsible for providing Emergency Medical Services (EMS) with the MOST form when a resident was being transferred to the hospital. She stated she was unsure if a DNR form had been completed for Resident #280 and reported a DNR form should have been in the chart at the nurse's station. An interview was conducted 5/3/2024 at 8:41 am with the Director of Nursing (DON). The DON reported that when a resident is admitted to the facility she will assess to see if there were any advanced directives in place and enter the code status order in the Electronic Health Record (EHR). The DON stated the SW and medical team went over code status with the family. At that time the SW and medical team would complete a DNR or MOST form. The DON reported she was not aware that Resident #280's DNR could not be found when she was transferred out of the facility on 3/5/2024.

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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. 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. (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 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. 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. (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 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. 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. (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 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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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 50045 Based on record review and staff interviews the facility failed to implement their abuse policies and procedures by not submitting an Initial Allegation Report within two hours of being notified of Resident neglect on 4/30/2024 at 6:10 PM and the facility continued to place residents at risk for neglect as they allowed Nurse #1 and Paramedic #1 to continue working after being notified of the neglect, for 1 of 3 residents (Resident #280) reviewed for abuse. Additionally, staff failed to report an allegation of staff to resident abuse to administration immediately and the facility failed to notify law enforcement of the abuse allegation for 1 of 3 residents (Resident #39) reviewed for abuse. The findings included: A review of the facility's North Carolina resident Abuse Policy revised 8/30/2023 stated neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional stress. The policy also stated, if the event that caused the allegation involves an allegation of Abuse or serious bodily injury, it should be reported to the Department of Health (DOH) immediately, but not later than 2 hours after the allegation is made. The policy further stated the facility should take whatever steps are necessary to protect residents and to prevent further acts of abuse, neglect, misappropriation of property, drug diversion, or fraud while the investigation is in progress. Additionally, the policy stated, Facility staff must immediately report all such allegations to the Administrator/Abuse Coordinator. The Administrator/Abuse Coordinator will immediately begin an investigation and notify the applicable local and state agencies in accordance with the procedures in this policy. The policy continued If the facility suspects that a crime has been committed, it will report that suspicion it will report that suspicion in accordance with its crime reporting policies. 1. The Administrator, Director of Nursing (DON), and Regional Nurse Consultant were notified on 4/30/2024 at 6:08 pm of Resident neglect that occurred on 3/5/2024 when Nurse #1 found Resident #280 to be only responsive to painful stimuli. Nurse #1 failed to initiate Emergency Medical Services (EMS), perform a head-to-toe assessment, ongoing assessments, and ongoing vital sign monitoring (including blood sugar checks). After Nurse #1 gave shift report to Paramedic #1 on 3/5/2024 at 6:30 pm, Paramedic #1 failed to perform a head-to-toe assessment, ongoing assessments, vital signs (including blood sugars), and failed to notify EMS until 8:10 pm on 3/5/2024. An interview was conducted on 5/1/2024 at 8:57 am with the Administrator, Regional Nurse Consultant, and DON. The Regional Nurse Consultant and DON stated they had not completed the required Initial Investigation Report and that it had slipped their minds. The Administrator stated he did not know that it had to be completed since State Surveyors were already onsite. Review of the Initial Allegation Report dated 5/1/2024 at 9:32 am revealed no accused employees listed for the neglect of Resident #280 that occurred on 3/5/2024. Documentation (continued on next page)

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

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed the facility became aware of the neglect on 4/30/2024 at 6:10 pm. The allegation details stated resident was not sent to the hospital timely. Orders received to send resident to the hospital by off-going nurse. The on-coming nurse assumed 911 had been called by off-going nurse. When he realized that EMS had not arrived to pick-up the resident, he called 911 and EMS arrived to transport the resident to the hospital. Due to the miscommunication between nurses, there was a delay in getting the resident to the hospital. Documentation further revealed there was no physical or mental harm because of the neglect. Review of Nurse #1 ' s timecard dated 4/30/2024 revealed Nurse #1 clocked in at 6:15 am and clocked out from her shift at 7:00 pm. Review of Paramedic #1 ' s timecard dated 4/30/2024 revealed Paramedic #1 clocked in at 6:15 pm and had not clocked out until 5/1/2024 at 8:00 am. An interview was conducted on 5/1/2024 at 3:48 pm with the Scheduler. The Scheduler reported Paramedic #1 had worked night shift beginning at 6:30 pm on 4/30/2024 and ending at 6:30 am on 5/1/2024. She reported Nurse #1 was scheduled to be back on orientation starting tomorrow (5/2/2024). The Scheduler reported she was not aware if either Nurse #1 or Paramedic #1 had been suspended because she had not been advised to take them off the schedule. An interview was conducted on 5/1/2024 at 3:40 pm with the Administrator. The Administrator reported Nurse #1 had been suspended after her shift on 4/30/2024 but Paramedic #1 had not been. He had not given any reason why Paramedic #1 was not suspended. An interview was conducted on 5/1/2024 at 3:40 with the Regional Consultant reported she was unsure whether Nurse #1 or Paramedic #1 had been suspended but knew that Paramedic #1 had worked night shift starting at 6:30 pm on 4/30/2024. A follow-up interview was conducted on 5/1/2024 at 3:53 pm with the Regional Nurse Consultant. The Regional Nurse Consultant stated she had just gone and spoken with the Scheduler and had Nurse #1 removed from the schedule for 5/2/2024. She was not aware Nurse #1 had not been suspended and reported she should have been. The Regional Nurse Consultant stated Paramedic #1 was being suspended. She stated Administrative Nursing Staff had failed to do the mandatory two-hour reporting and had not thought about suspending Nurse #1 and Paramedic #1 while they conducted their investigation. The Regional Nurse Consultant stated the facility had not followed it ' s policy for reporting abuse and neglect. 49366 2. Record review of the 24-hour initial Facility Entity Report dated 1/28/24 revealed the allegation of staff to resident abuse of Resident #39 had occurred on Friday, 1/26/24. The DON was notified via telephone on 1/28/24 at 1:30 PM who then contacted the administrator. Resident #39 wheeled herself into the nursing station and Nurse #14 instructed her to leave and Resident #39 refused. Nurse #14 grabbed the wheelchair to remove her from the nursing station. Resident #39 resisted and struck Nurse #14. Nurse #14 grabbed Resident #39's arms and proceeded to push her out of the nurse's station. The facility did not notify law enforcement. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Nurse #1 was attempted on 5/1/24 at 9:11 AM and she did not return the call and was not working at the facility. During an interview with the DON on 5/2/24 at 10:19 AM, she stated Nurse #1 reported the allegation on Sunday, 1/28/24 at 1:30 PM. She explained law enforcement was not called as she believed a crime had not been committed. The DON explained Nurse #1 stated she thought about it over the weekend and decided she needed to report what she saw on Friday. Nurse #14 went off duty right after the incident and did not return to the facility. She provided a statement over the phone. The DON explained that she was terminated during the investigation. In an interview with the Administrator on 5/2/24 at 10:22 AM, stated even though the incident was an abuse allegation, he was unsure if law enforcement needed to be contacted because the resident was not harmed.

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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 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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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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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Care of Waynesville	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], 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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50046 Based on observations, record review, registered dietician, dialysis center, staff and physician interviews, the facility failed to maintain ongoing communication with the dialysis center, failed to assess a resident post dialysis, and failed to implement orders from the dialysis center for fluid restrictions and a renal diet for 1 of 1 resident reviewed for dialysis (Resident #19). The findings included: Resident #19 was re- admitted to the facility on [DATE]. Her medical diagnoses included end stage renal disease. Review of the Annual Minimum Data (MDS) assessment 1/26/24 revealed Resident #19 was cognitively intact and coded for dialysis. Review of Resident #19's care plan last reviewed 1/16/24 revealed she had a hemodialysis care plan related to end stage renal disease and receiving dialysis on Monday/ Wednesday/ Friday. The care plan goal was to maintain patent vascular access and for vascular to remain free of signs/ symptoms of infection. The hemodialysis care plan interventions included to collaborate care with the dialysis center, provide diet per order, administer and/or restrict fluids as indicated by the physician, monitor for bleeding and sepsis, monitor skin around vascular access for redness, warmth, swelling, report to physician/ dialysis center fever, chills, or hypotension. She also had a nutrition care plan that indicated she was at nutrition/ hydration risk due to end stage renal disease. The nutrition care plan interventions included to maintain monthly contact with the dialysis center dietician. Her care plan did not include assessing her dialysis access site post dialysis, to obtain weight, or vital signs post dialysis. Review of Resident #19's active physician orders April 2024 revealed she did not have an order for fluid restrictions or a renal diet. Resident #19's diet order dated 11/22/22 read: no added salt (NAS)/ low concentrated sweets (LCS), regular texture diet. She had an active order for hemodialysis every Monday, Wednesday, Friday at the dialysis center. She had a physician's order dated 4/11/24 that read: document post dialysis note every Monday, Wednesday, Friday in the afternoon for monitoring post dialysis. Review of Resident #19's electronic medical record (EMR) revealed she had one post dialysis nursing note documented on 4/12/24 that said Resident #19 had no complaints, no symptoms of distress, and included her vital signs. The note did not indicate her dialysis access site had been assessed. There were no other post dialysis nursing notes documented in Resident 19's EMR from 4/1/24-4/28/24. Review of Resident #19's EMR revealed there were no post dialysis vital signs documented in the EMR for the following dates: 4/1/24, 4/3/24, 4/8/24, 4/10/24. There were no post dialysis vital signs documented under vital signs for the month of March 2024. Review of Resident #19's EMR revealed she had weights documented on 2/13/24, 3/6/24, and 4/4/24. There were no post dialysis weights documented in Resident #19's EMR. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with Nurse #2 on 4/29/24 at 3:20 PM. She stated there was supposed to be a communication folder that was sent back and forth between the facility and the dialysis center. She said Resident #19 returned from dialysis today (4/29/24) without any type of papers or communication from the dialysis center. She stated Resident #19 would sometimes return from dialysis with papers but not all the time. She explained the papers Resident #19 returned with sometimes had written instructions. Nurse #2 said she did not call the dialysis center when Resident #19 returned after dialysis to obtain information. A telephone interview was performed on 4/29/24 at 3:44 PM with the Dialysis Center Nurse. She reviewed Resident #19's dialysis chart and stated that Resident #19's orders included a renal diet and that she should be on a renal diet. She explained a renal diet would be low sodium, low potassium, and low phosphorous diet. The Dialysis Center Nurse stated Resident #19 had an order for fluid restrictions and was supposed to be on a 1000 milliliter (ML) per day fluid restriction. She stated the last dialysis center Registered Dietician (RD) note dated 3/27/24 stated Resident #19's fluid was high, and he had talked about her fluid needing to be limited. She said the note stated he had called and spoken to the facility regarding Resident #19's fluid intake needing to be limited. The note did not say who he had spoken to at the facility. She stated the dialysis center called the facility if Resident #19 had any issues or changes. She said the RD at the dialysis center would call the facility and ask to speak to the nurse taking care of Resident #19. She stated the Dialysis center did not routinely send dialysis notes or RD notes to the facility unless they were requested by the facility. The dialysis center RD was not working and not available to be interviewed. An interview was performed with the facility's Dietary Manager on 4/29/24 at 4:21 PM. She stated the facility's therapeutic diets were LCS and NAS. She stated the facility could do a renal diet depending on the resident and if the facility RD said the resident needed a renal diet. She said that would be up to the RD. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A telephone interview was conducted on 04/30/24 at 8:37 AM with the facility RD. The RD stated she communicated with the RD at the dialysis center but that the last time she had spoken to the dialysis center RD had been 6 months ago, she did not say what was discussed when they had last spoken. She stated the dialysis center had a new RD and she had not yet spoken to him because he was new to the job. She stated she communicated on an as needed basis with the dialysis center. The RD explained as needed communication as if a resident had issues with labs or issues at dialysis. The RD stated it had been a while since she last communicated or spoken with anyone at the dialysis center. She explained a while was probably 6 months. The RD stated she left it up to the dialysis center to contact her if there was an issue but that she would call them if she felt like something was not right with a resident. She stated the dialysis center completed lab work weekly but that she did not get lab results from the dialysis center unless she called and requested them. The RD stated if a resident returned from dialysis with information, she needed to be aware of she would be notified by the Quality Assurance Nurse (QA nurse). The RD stated she saw all the dialysis residents monthly to do a review and check in on them. She stated the facility was able to do a renal diet. She stated she determined if a resident needed a renal diet by the diet present on admission and what the physician orders were. The RD stated if a dialysis resident did not have a renal diet, it could cause a resident's sodium levels and potassium levels to be abnormal, and increased edema (swelling). She stated the facility did fluid restrictions for residents if they were ordered. The RD stated she left it up to the dialysis center to decide if a dialysis resident needed fluid restrictions. She said the facility would follow the fluid restriction guidelines if the dialysis center felt like a resident needed fluid restrictions. The RD stated she was not aware that the dialysis center wanted Resident #19 to have a renal diet and fluid restrictions. She stated the dialysis center had not contacted her and she had not received that information. She stated she was aware that Resident #19 sometimes missed dialysis treatments due to refusing to go. The RD stated that a renal diet and fluid restrictions could help manage some of the lab issues and extra fluid associated with missed dialysis treatments. An interview was performed on 05/01/24 at 9:56 AM with Nurse #7. She was the assigned nurse for Resident #19. She stated she was not aware of a dialysis communication form that was sent with residents when they went to dialysis. She stated she did not send any type of communication form with Resident #19 when she went to dialysis today. She stated that Resident #19 did not return from dialysis with any type of paperwork or communication that told how she did at dialysis, if she had issues, or how much weight and fluid was taken off. She stated she had not ever received any notes from dialysis. Nurse #7 stated Resident #19 sometimes refused to go to dialysis 1-2 times a week. She said the dialysis center would offer Resident #19 to come the next day for a makeup dialysis day. She stated the transportation aide would coordinate the makeup dialysis appointment if Resident #19 agreed to go. She stated there was no type of special monitoring the facility did such as extra vital signs or weight checks when Resident #19 refused to go to dialysis. She stated she did not call and talk to the dialysis center when Resident #19 refused to go to dialysis to see if any type of monitoring was recommended. She said she had not called the dialysis center when Resident #19 returned to the facility after dialysis to get information. Nurse #7 stated she thought the dialysis center should send some type of form or paperwork back after dialysis to communicate with the nurses at the facility about what the resident's weights were, if the dialysis site was good, how they had tolerated the treatment, and if they had any issues. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 5/1/24 at 10:51 with Nurse #8. He stated he was often Resident #19's assigned nurse. He stated the facility did not receive any type of communication from the dialysis center when residents returned to the facility after dialysis treatments. He said he did not call the dialysis center when Resident #19 returned to the facility after dialysis to obtain information. Nurse #8 said it had been over a month since he had last spoken to the dialysis center. He said the last time he had spoken to the dialysis center they had called and said Resident #19 had missed several appointments and the facility needed to do a better job about getting her to go. An interview was conducted with the Medical Director on 5/1/24 at 1:49 PM. He stated he was aware that Resident #19 missed dialysis 2-3 times a month. The Medical Director said he had not received communication from the dialysis center. He stated there should have been communication from the dialysis center with the facility if the dialysis center felt Resident #19 needed to be on a renal diet or fluid restrictions. He said he was not aware of that. An interview was performed on 05/01/24 at 3:18 PM with the Director of Nursing (DON). She stated the facility did not receive any paperwork or communication from the dialysis center when residents returned from dialysis. She said sometimes the dialysis center would call the facility if there were concerns or new orders. She said when the dialysis center called the facility, they would speak to the nurse who was assigned to take care of the resident. She stated the facility did not request notes or labs from the dialysis center unless there was a problem, and that the dialysis center did not send them unless the facility specifically requested them to. The DON stated she had reached out to the dialysis center in the past about sending post dialysis communication back with the residents but that it did not help. She stated the RD called the dialysis center if she had a specific concern or question. The DON said she was aware that Resident #19 refused to go to dialysis sometimes. She said sometimes Resident #19 did not go because she was sick and sometimes, she just did not want to go. The DON stated the facility could do a renal diet and fluid restrictions for residents if it was ordered. She stated she was not aware that the dialysis center wanted Resident #19 to have a renal diet or fluid restrictions. The DON verbalized a renal diet with low potassium and fluid restrictions could help manage extra fluid and elevated potassium levels associated with missed dialysis treatment. An interview was conducted on 05/02/24 at 10:37 AM with the Administrator. He said the dialysis center did call the facility at times about residents and that was the only type of communication the facility received from the dialysis center. He stated he thought the RD should have communicated with the dialysis center more frequently than 6 months. He stated he felt the RD should talk with the dialysis center RD at least quarterly.

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50045 Based on record review, facility staff and Medical Director (MD) interviews, the facility failed to ensure that facility staff (Nurse #1 and Paramedic #1) had completed Skills Competency's and required floor/unit orientation days with a preceptor prior to taking a resident assignment independently. On [DATE] at 2:30 pm, Nurse #2 informed Nurse #1 that Resident #280 had been excessively sleepy during her shift. Nurse #1 failed to assess Resident #280 until 5:00 pm, at which time Resident #280 was only responsive to painful stimuli. Nurse #1 was instructed at 6:30 pm to transfer Resident #280 to the hospital for evaluation and treatment. Nurse #1 failed to notify Emergency Medical Services (EMS) and was under the assumption that the oncoming staff member, Paramedic #1 (employed by the facility and functioning as a nurse), was going to notify EMS. Paramedic #1 failed to assess Resident #280 until 8:00 pm when he realized that EMS had not come to transfer the resident. Paramedic #1 called EMS at 8:10 pm and was told that EMS had not been contacted. Resident #280 was transferred to the hospital and later died . The deficient practice occurred for 2 of 5 facility staff members (Nurse #1 and Paramedic #1) reviewed for competency and had the high likelihood for causing the potential for serious harm to other residents. Immediate jeopardy began on [DATE] when the failure to verify Nurse #1 and Paramedic #1's competency and skills resulted in delayed treatment of Resident #280. Immediate jeopardy was removed on [DATE] when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity level E (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to complete employee education and ensure monitoring systems put into place are effective. The findings included: A review of Paramedic #1's job description, titled Paramedic for alternative practice setting, revealed duties which included providing direct nursing care to residents, assess resident's needs, develop individual care plan, administer nursing care, evaluate nursing care, and supervise nursing assistants and other personnel in the delivery of nursing care within his scope of practice. The job description further revealed that Paramedic #1 had not signed that he had reviewed his job description and agreed to abide by his job description during employment. Paramedic #1's job description was signed by the Director of Nursing (DON) on [DATE] and by the MD. A review of Paramedic #1's Orientation and Skills Competency Checklist dated [DATE] and was hired on [DATE] revealed he had not been checked off on the following: who to contact if needed supplies are not found, tube feeding, demonstrating knowledge and skill in the use of the resident individualizing plan of care for providing resident centered care and updating the plan of care as needed, demonstrating knowledge and skill in identifying, investigating, reporting, notifications, and follow up evaluations of change in resident conditions, demonstrating knowledge and understanding of facility quality improvement initiatives (QAPI), survey process, and correct tube placement. The Orientation and Skills Competency Checklists were signed as complete by Paramedic #1 on [DATE] and by the DON on [DATE]. The Orientation and Skills Competency Checklists revealed areas for the employee (Paramedic #1), DON, and Nurse preceptors to sign, however there was no space for the MD to sign as verification the Competency Checklist had been completed. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview was conducted on [DATE] at 9:08 am with the SDC verified that Paramedic #1's Orientation and Skills Competency Checklist revealed he had not been checked off on who to contact if needed supplies are not found, tube feedings, demonstrating knowledge and skill in the use of the resident individualizing plan of care for providing resident centered care and updating the plan of care as needed, demonstrating knowledge and skill in identifying, investigating, reporting, notifications, and follow up evaluations of change in resident conditions, demonstrating knowledge and understanding of facility quality improvement initiatives (QAPI), survey process, correct tube placement, and the DON had signed verifying it was completed on [DATE]. She reported she was unsure why Paramedic #1's competency skills checks were not completed and that she had not noticed it. She verbalized all areas should have been checked off prior to Paramedic #1 taking a resident assignment independently . An interview was conducted on [DATE] at 9:25 am with the DON regarding Paramedic #1. The DON verified that Paramedic #1's Orientation and Skills Competency Checklist revealed he had not been checked off on who to contact if needed supplies are not found, tube feedings, demonstrating knowledge and skill in the use of the resident individualizing plan of care for providing resident centered care and updating the plan of care as needed, demonstrating knowledge and skill in identifying, investigating, reporting, notifications, and follow up evaluations of change in resident conditions, demonstrating knowledge and understanding of facility quality improvement initiatives (QAPI), survey process, correct tube placement, and she had signed verifying it was completed on [DATE]. She reported she was unsure why Paramedic #1's competency skills checks were not completed and that it must have been an oversight. She verbalized all areas should have been checked off prior to Paramedic #1 taking a resident assignment independently. A review of Nurse #1's Orientation and Skills Competency Checklist dated [DATE] and was hired on [DATE] revealed she had not been checked off on Pharmacy Services, Emergency box and/or Omnicell (medication dispensing machine), Emergency Medications, Diagnosis for Medication, Review of Required Assessments (paper or Electronic), Head to Toe Assessment and Documentation, Device List, Vital Signs, and had not completed her 4 required days of floor/unit training with a preceptor. The DON and Nurse #1 had signed the Checklist as complete. The Orientation and Skills Competency Checklists revealed areas for the employee (Nurse #1), DON, and Nurse preceptors to sign, however there was no space for the MD to sign as verification the Competency Checklist had been completed. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview was conducted on [DATE] at 9:08 am with the Staff Development Coordinator (SDC) regarding Nurse #1. The SDC reported most of the facility staff orientation was completed by Human Resources. She reported as the SDC she educated facility staff about Personal Protective Equipment (PPE), handwashing, and administered their drug test. The SDC verbalized floor nursing staff completed skills competency check offs for newly hired employees during their required floor/unit training days. She stated after the Skills Competency Check List had been completed, the DON or her would review the competency and sign off to verify that the competencies had been completed. The SDC stated that precepting staff are required to date and sign/initial all skills areas of the competency sheet. She reported if a date or initials were missing next to a competency skill, it would be assumed that the staff member had not completed that competency check. She reported the DON would make the determination if a facility staff member could take a resident assignment independently without having completed all the competency skill check offs. The SDC verified that Nurse #1's Orientation and Skills Competency Checklist revealed she had not been checked off on Pharmacy Services, Emergency box and/or Omnicell, Stat Meds, Diagnosis for Medication, Review of Required Assessments (paper or EHR), Head to Toe Assessment and Documentation, Device List, Vital Signs, had not completed her 4 required days of floor/unit training with a preceptor, and the DON had signed verifying it was completed on [DATE]. She reported she was unsure why Nurse #1's competency skills checks were not completed and that she had not noticed it. She verbalized all areas should have been checked off prior to Nurse #1 taking a resident assignment independently. An interview was conducted on [DATE] at 9:25 am with the DON regarding Nurse #1. The DON reported the SDC was responsible for ensuring staff had completed Competency Skills Checkoffs and the required floor/unit training days. She reported that competencies were required to be completed before a Nurse or Paramedic would have a resident assignment on their own. The DON verified that Nurse #1's Orientation and Skills Competency Checklist revealed she had not been checked off on Pharmacy Services, Emergency box and/or Omnicell, Emergency Medications, Diagnosis for Medication, Review of Required Assessments (paper or EHR), Head to Toe Assessment and Documentation, Device List, Vital Signs, had not completed her 4 required days of floor/unit training with a preceptor, and that she had signed verifying it was completed on [DATE]. She reported that she did not notice there were missing competency skills checks on Nurse #1's form, and that she must have overlooked it. She reported the skills competency checks should have been completed prior to Nurse #1 taking a resident assignment independently. 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. Resident #280's vital signs were entered on [DATE] at 6:41 pm (which were obtained at 5:30 pm per Nurse #1). 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). 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. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Further review of Resident #280's medical record revealed no head-to-toe assessment, 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 employed by the facility and functioning as a nurse) the last 24 hours and he was told in 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 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. A telephone interview was conducted on [DATE] at 1:12 pm with Nurse #1. Nurse #1 reported she had received training for Pharmacy Services, Emergency box and/or Omnicell (medication dispensing machine), Emergency Medications, Diagnosis for Medication, Review of Required Assessments (paper or Electronic), Head to Toe Assessment and Documentation, Device List, and Vital Signs. She reported she was not aware those skills had not been checked and initialed on the Orientation and Skills Competency Checklist. Nurse #1 reported she received at least five days of training and had spent each shift on a different hall with a different preceptor. Nurse #1 was not able to explain why the orientation days were not reflected on the Orientation and Skills Competency Checklist. She reported she was not able to recall if Resident #280 was a diabetic, but she voiced she would have referred to the Electronic Health Record (EHR). (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A telephone interview was conducted on [DATE] at 4:09 pm with Paramedic #1. Paramedic #1 reported he had not received much of an orientation and from what he was able to recall it was approximately three days long. He reported during those three days he was partnered with a seasoned nurse at the facility, shown how to use the computer system, which assessments to complete, and information about the facility/residents. Paramedic #1 reported since he had learned the computer charting quickly, the nurse preceptor had recommended he be released to start on his own. Paramedic #1 reported he was aware there were areas of his Competency Skills Checkoffs that were not completed, but he thought the areas missing were administrative sections that had not pertained to his role. He was unaware who to contact if needed supplies are not found, tube feedings, demonstrating knowledge and skill in the use of the resident individualizing plan of care for providing resident centered care and updating the plan of care as needed, demonstrating knowledge and skill in identifying, investigating, reporting, notifications, and follow up evaluations of change in resident conditions, demonstrating knowledge and understanding of facility quality improvement initiatives (QAPI), survey process, and correct tube placement had not been checked off. An interview was conducted on [DATE] at 10:45 am with the Administrator. The Administrator was not aware Nurse #1 and Paramedic #1 had not completed their Skills Competency Checkoffs and did not know why they had not been completed. An interview was conducted on [DATE] at 1:22 pm with the MD. The MD reported he was aware that Paramedics worked in the facility and performed nursing tasks. He reported that he would have wanted Paramedics and Nurses to have completed competency skills checks prior to taking a resident assignment independently and practicing under his license. He reported that he was unaware that Nurse #1 had not completed her competency skills check offs and required orientation days and he reported he was also unaware Paramedic #1 had not completed his competency skills check offs. Paramedic #1 signed the Orientation and Skills Competency Checklists on [DATE]. The Administrator was notified of Immediate Jeopardy on [DATE] at 10:50 am. 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 as a result of the noncompliance: The facility failed to ensure that Nurse #1 and Paramedic #1 had completed Orientation and Skills Competency Checklists prior to taking a resident assignment/medication cart. Review of Nurse #1's Orientation and Skills Competency Checklist, signed by the Director of Nursing (DON) as complete on [DATE], revealed Nurse #1 had not been signed off on Pharmacy Services, emergency medication back up kit and or electronic medication dispenser (Omni Cell), Diagnosis for Medication, Review of Required Assessments (paper or EHR), Head to Toe Assessment and Documentation, Device List, Vital Signs, and had not completed her 4 required days of floor/unit training with a preceptor. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Paramedic #1's Orientation and Skills Competency Checklist, signed by the DON as complete on [DATE], revealed Paramedic#1 had not been signed off for the following: who to contact if needed supplies are not found, tube feeding, demonstrating knowledge and skill in the use of the resident individualizing plan of care for providing resident centered care and updating the plan of care as needed, demonstrating knowledge and skill in identifying, investigating, reporting, notifications, and follow up evaluations of change in resident conditions, demonstrating knowledge and understanding of facility quality improvement initiatives (QAPI), survey process, and checking for proper tube placement prior to each use per policy. On [DATE] Nurse #1 will complete the required days of floor/unit training with a preceptor prior to her next shift assigned to work. The Director of Nursing or Designee will sign off competencies for Nurse #1 on the Pharmacy Services, use of emergency medication back up kit, and or electronic medication dispenser (Omni Cell), Stat Meds, Diagnosis for Medication, Review of Required Assessments (paper or EHR), Head to Toe Assessment and Documentation, Device List, Vital Signs prior to next shift assigned to work. Paramedic #1 was working his two weeks' notice and the Director of Nursing released him on [DATE] before his two-week notice expired. On [DATE] The Director of Nursing or Designee audited the employee files of licensed staff and Paramedics to ensure orientation and skills competency checklist were completed, any negative findings will be corrected immediately, and staff placed back into orientation or skills check off completed for any area missed during orientation. 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 Regional Director of Clinical Services educated the Director of Nursing, Assistant Director of Nursing, Administrator, Scheduler and Human Resources on the orientation process to include the required days of floor/unit training with a preceptor and completion of the skills competency checklist. On [DATE] the Director of Nursing or Designee will ensure all newly hired licensed staff have completed the required days of floor/unit training with a preceptor prior to being given an assignment. On [DATE] the Assistant Director of Nursing or Designee will complete the skill competency checklist for all newly hired licensed staff and Paramedics. The Director of Nursing or Designee will ensure all newly hired licensed staff and Paramedics have completed skills competency checklist prior to being given an assignment. On [DATE] Ad Hoc QAPI was completed related to following orientation policy and ensuring the skill checklist is completed for licensed staff and Paramedics prior to taking their first assignment. Alleged Date Immediate Jeopardy removal: [DATE] (continued on next page)

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F 0726 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 in-service sign in sheets revealed the Scheduler, DON, Assistant Director of Nursing (ADON)/SDC, Human Resources (HR), and Administrator received education regarding the orientation process, completion of the required number of floor/orientation days with a preceptor, and the importance of ensuring that all skills competency checks were completed for facility staff members prior to taking an assignment independently. Review of the facility documentation dated [DATE] revealed audits were completed for all Nurse Aides (NA), Nurses, and Paramedics. The facility's Immediate Jeopardy removal date of [DATE] was confirmed.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50045 Based on observations, record review, staff, and Pharmacy Consultant interviews the facility failed to maintain a medication error rate of less than 5% by having 2 errors out of 25 opportunities which resulted in an 8% medication error rate. This affected 1 of 4 residents observed on medication pass (Resident #282). The findings included: Resident #282 was admitted to the facility on [DATE] with diagnoses including diabetes, genitourinary conditions, and a Urinary Tract Infection (UTI). A physician's order dated 4/26/2024 read Meropenem (antibiotic) Intravenous (IV) solution reconstituted 1 gram, use 1 gram IV every 8 hours for Extended-spectrum beta-lactamases (ESBL)/pseudomonas bacteria urine, mix with 100 milliliters (mLs) 0.9% Normal Saline (mixing solution), to infuse over 3 hours. A physician's order dated 4/26/2024 read Normal Saline flush IV solution (sodium chloride flush) use 3 mLs IV five times a day for heparin lock patency (to ensure IV was patent). A review of the April 2024 Medication Administration Record (MAR) revealed Resident #282 received Meropenem 1 gram IV on 4/27/2024 (at 12:00 am, 8:00 am, and 4:00 pm), on 4/28/2024 (at 12:00 am, 8:00 am, and 4:00 pm), and on 4/29/2024 (at 12:00 am and 8:00 am). An observation of Nurse #11 preparing Resident #282's medication was made on 4/29/2024 at 8:35 am. Nurse #11 was observed mixing the dual chamber bag of antibiotic with 1 gram of Meropenem and 50 mLs of Normal Saline. Nurse #11 primed the IV tubing at Resident #282's bedside and had the pump programmed for Meropenem 1 gram to infuse at a rate of 100 mLs per hour. Nurse #11 failed to flush the IV prior to connecting the primary IV tubing to Resident #282. The nurse was stopped prior to administration of the IV antibiotic. An interview was conducted on 4/29/2024 at 8:40 am with Nurse #11. Nurse #11 reported she was not aware that IVs were required to be flushed and thought only Peripherally Inserted Central Catheters (PICCs) were required to be flushed. Nurse #11 reported she had overlooked the Normal Saline flush on the Medication Administration Record (MAR). Nurse #11 reported she was not aware that the Meropenem solution was mixed wrong because she had just used what was sent from the pharmacy with Resident #282's name on it and assumed that it was okay. She reported the bag sent from the pharmacy stated to infuse the medication at 100 mL per hour. Nurse #11 verified the order and rate of infusion on the MAR and the concentration of medication sent from the pharmacy were not the same. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 4/29/2024 at 10:21 am with the Pharmacy Consultant. The Pharmacy Consultant verified Resident #282 had an order for Meropenem 1 gram to be infused every 8 hours, however she was not able to see the part of the order that said to mix the medication with 100 mL of 0.9% Normal Saline. The Pharmacy Consultant reported the ordered concentration was usually what was given at the medical center and stated their pharmacy only kept premixed medication. The Pharmacy Consultant reported that the pharmacy will usually notify the facility to change the order, however they did not because the nurses at the facility knew the premixed solution of Meropenem was the only concentration that they carried. The Pharmacy Consultant reported pharmacy staff should have advised the facility to change the order and change the infusion rate to be over 30 minutes instead of 3 hours (which was on the order). The Pharmacy Consultant reported the discrepancy in the solution sent to the facility was an oversight on the pharmacy's behalf. The Pharmacy Consultant verified IVs (the IV access point) should be flushed before and after IV medication administration. An interview was conducted on 5/1/2024 at 1:22 pm with the Medical Director (MD). The MD reported the hospital orders for Meropenem were different from what would be ordered at the facility. The MD verbalized that the dose and rate Nurse #11 administered to Resident #282 would not have been harmful to the resident and was what the facility typically used. The MD reported IVs (the IV access point) should be flushed before and after IV medication administration. An interview was conducted on 5/3/2024 at 8:54 am with the Director of Nursing (DON). The DON reported Nurse #11 had come to her on 4/29/2024 and reported the two medication errors from the medication pass for Resident #282. The DON reported Nurse #11 had just forgotten about flushing IVs. An interview was conducted on 5/3/2024 at 9:37 am with the Administrator. The Administrator reported he was made aware, by the DON, of the medication errors made by Nurse #11 on 4/29/2024.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49366 Based on observations, record review, resident and staff interviews, the facility failed to secure medications found at the bedside for 1 of 1 resident reviewed for medication storage (Resident #53). The findings included: Resident #53 was admitted to the facility on [DATE] with diagnoses which included unspecified dementia, hypertension, and anxiety. A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #53 was severely cognitively impaired. A review of Resident #53's Medication Administration Record (MAR) revealed she was prescribed the following medications on the morning of 4/29/24: Aspirin 81mg, Ferrous Sulfate tablet 325mg, Isosorbide Mononitrate ER tablet 30 mg, Escitalopram tablet 10mg, and Lisinopril tablet 10mg. An observation on 4/29/24 at 8:59 AM revealed medications in a cup on the bedside table to the right of Resident #53's bed. Resident #53 was lying in bed at the time of the observation and stated that she was not aware that there were medications on her table or that she needed to take them. An observation and interview with Nurse #8 on 4/29/24 at 9:09 AM revealed he was the medication nurse for the 500 hall. He observed the medication cup filled with pills on Resident #53's bedside and stated he had walked away, and she did not take them. Resident #53 proceeded to swallow the pills as directed by Nurse #8 during the observation. An interview with the Director of Nursing (DON) on 5/02/24 10:03 AM revealed she expected nurses to observe a resident while medications were administered. She stated that it was never acceptable to leave pills next to the bedside.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50046 Based on observations and staff interviews, the facility failed to maintain clean and sanitary kitchen conditions as evidence by debris present on the kitchen floor and in the tile grout, dried food particles on a utility cart that was used to store clean dishware, dried debris on the steam table hood, dried debris on the outside oven surfaces. The facility also failed to ensure ready for use metal pans, insulated dome plate covers, insulated plate under liners, and dishware were clean and not stacked wet. This occurred for 2 of 2 kitchen observations. These practices had the potential to affect food served to residents. The findings included: 1. An initial tour of the kitchen occurred on 4/28/24 at 11:00 AM with the Dietary Manager (DM). The initial observation of the serving line and dishwashing area revealed the following: a. Dishware that was ready for use was put away and stacked wet (wet-nested). - 2 out of 10 divided plates - 20 out of 24 insulated plate under liner bottoms - 3 out of 5 large rectangle metal pans - 5 out of 6 deep small square metal pans b. Dishware that was ready for use was put away and stacked dirty. - 3 out of 10 divided plates had yellow particles. - 13 out of 16 saucers had yellow and black particles. - 7 out of 20 dinner plates had yellow, brown and/or black particles. - 10 out of 20 insulted plate dome plate covers had white and black particles. - 1 out 2 small rectangle metal pans had brown/black particles. - 5 out of 6 small square metal pans had brown/black particles. c. A plastic utility cart was observed to be dirty with loose and dried food particles, and dried orange crusted debris present on the cart surface and along the edges of the cart. The utility cart was used to store clean stacked dishes including diner plates, saucers, and dome plate covers. d. The kitchen floors had loose trash and food debris present on the floor surface and in the tile grout. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	e. The oven had food particles and dried brown crusted debris along the outer surfaces of the oven. f. The steam table hood had food particles and dried crusted debris along the top and edges of the hood. The underneath of the steam table hood had a large amount of dried brown crusted debris along the entire length of the underneath of the hood. An interview was performed with the DM on 4/28/24 at 11:20 AM. The DM stated dietary staff normally let the dishes sit until they are dry and put them on a rack to dry. She said the dietary staff normally checked to ensure dishes were clean and dry before putting them away. The DM said the kitchen was short staffed this morning (4/28/24) because of a call out. The DM said they were not usually short staffed except for when they had a call out and she would come and help when there was a call out if needed. She explained she thought the dietary staff this morning got in a hurry and were rushing because they were short staffed and didn't let the dishes sit and dry or check them to ensure they were clean. The DM said the dietary staff should have checked the dishes to ensure they were clean and dry before putting them away and stacking. The DM stated the steam table hood was cleaned after every meal and the top/ underneath of the hood should be cleaned every night. The DM looked at the underneath of the steam table hood and said she was not aware the underneath was dirty. She said there was no cleaning schedule for the underneath of the steam table hood but that there should be. She said the outside surfaces of the oven were scheduled to be cleaned today per the kitchens cleaning schedule. 2. A follow up observation of the kitchen was completed on 4/30/24 at 11:34 AM with DM and the following concerns were identified: g. Dishware that was ready for use was put away and stacked wet (wet-nested). - 4 out of 15 insulated plate liner bottoms - 1 out of 3 divided plates h. Dishware that was ready to be used was put away and stacked dirty. - 8 out of 20 small round plates had brown/yellow particles. An additional interview was completed with DM on 4/30/24 at 11: 40 AM. The DM stated she had educated the dietary staff on checking to ensure dishware was dry and clean before being stacked and put away for use. She said she was not sure why the dishware was wet nested or dirty. The DM stated that was a problem and needed to be fixed. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with Dietary Aide #1 was conducted on 5/1/24 at 1:10 PM. She stated everyone who worked in the kitchen helped wash dishes. She explained the process for cleaning/ washing dishes. She said dietary received the dirty tray cart back from the dining room or halls. She stated the dietary staff would wear gloves when handling the dirty dishes. Dietary Aide #1 explained 2 staff would handle the dirty dishes and a different staff member handled the clean dishes to prevent any contamination between the dirty and clean dishes. She said one staff would scrap, she explained the scrap duty as separating the dishes on the tray and removing any trash or uneaten food from the trays/ dishes and discarding the waste. She said a second person would then load the dirty dishes into the dish machine washing tray and push the tray into the dish washer. Dietary Aide #1 said there was a red light on the dishwash machine that blinked and let them know when the dishes were done, and the machine can be opened. She stated a third person removed the clean dishes out of the dishwasher and made sure the dishes were clean and free from any food. She explained this was done by doing a visual inspection when the dishes came out of the machine and then the dishes were set up to dry. She said the dishes were left in the dishwash tray and set up in the dishwash tray at an angle that would allow them to dry. Dietary Aide # 1 stated once the dishes were dry, they would be stacked on the appropriate cart until next use. She said the person who put away and stacked the dishes should perform a secondary check to ensure the dishes were clean and dry before stacking them. She said the dietary staff also checked the dishes when they plated the food in the tray line and did not use a dish if it was wet or dirty. An interview was performed on 05/02/24 at 10:48 AM with the Administrator. He stated he was surprised about the kitchen sanitation. He stated he thought the kitchen was shorthanded and was rushing to get everything done. He stated the dietary staff should have checked the dishes to ensure they were clean and dry before putting them away.

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Autumn Care of Waynesville	360 Old Balsam Road Waynesville, NC 28786

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 50046 Based on observations, record review, staff and physician interviews the facility failed to initiate Enhanced Barrier Precautions (EBP) for a resident with an indwelling vascular access device. This deficit practice occurred for 1 of 1 resident (Resident # 19) reviewed for indwelling medical devices. The findings included: Review of the facility's policy and procedure revised on 4/15/2024, entitled Transmission-Based Precautions and Isolation Policy read in part: Enhanced Barrier Precautions (EBP) are intended to prevent transmission of multi-drug resistant organisms (MDROs) via contaminated hands and clothing of healthcare workers to high-risk residents. EBPs are indicated for high contact care activities for residents with chronic wounds and indwelling devices (such as central lines, urinary catheters, and trachs) and for all those colonized or infected with a MDRO currently targeted by the CDC. Review of the facility's EBP door signage in part read Everyone must: clean their hands before entering and when leaving the room. Providers and staff must also: wear gloves and a gown for the following high-contact resident care activities dressing, bathing/ showering, transferring, changing linens, providing hygiene, changing briefs, or assisting with toileting, device care or use: central lines, urinary catheter, feeding tube, tracheostomy, Wound care: any skin opening requiring a dressing. An observation was completed on 4/28/24 at 4:21 PM and revealed Resident #19 had a Permacath (a type of central venous catheter) in place to her right upper chest used for dialysis access. There was no personal protective equipment (PPE) located outside of her room door or in her room for staff to access to provide EBP. An observation on 4/29/24 at 9:45 AM revealed no PPE equipment was present outside the door or in Resident #19's room. An observation on 4/30/24 at 12:45 PM revealed no PPE present outside Resident #19's door or in her room. An interview was performed with Resident #19 on 4/28/24 at 4:21 PM. She stated her Permacath dressing was changed at dialysis when she went on Monday, Wednesday, and Friday. Resident #19 stated sometimes the dressing would peel up or start to come off at the facility and the nurses would change or reinforce the dressing. She did not say if staff wore gloves when they reinforced or changed her dressing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was performed with Nurse #2 on 4/30/24 at 9:30 AM. She stated if Resident #19's Permacath dressing peeled up she would reinforce the dressing and would use standard precautions, which she said would be to use gloves and hand-hygiene. She said she would maybe need to wear a gown but was unsure. She stated Resident #19 did not have a sign on her door that indicated additional PPE needed to be used for care. Nurse #2 stated some residents with wounds and catheters had PPE carts located outside their door and a sign on their door to let staff know to use PPE when providing direct care to protect the resident. She explained the administrative nursing staff decided who needed to be on this type of precaution and those residents had a sign on their door. Nurse #2 explained when Resident #19 returned to the facility after her dialysis treatments she was weaker and needed staff assistance for transfers. She said Resident #19 would usually call for staff to help with transfers and other activity of daily living tasks. Nurse #2 stated she thought a Permacath was considered an indwelling device and did not know why Resident #19 did not have EBP in place. She stated she had heard EBP was only for catheters and wounds but was not sure. Nurse #2 said she had received education on EBP from the facility and had been told EBP was supposed to be used for residents who had catheters and wounds when providing direct care to prevent the spread of germs. An interview was performed with NA #3 on 4/30/24 at 10:37 AM. NA #1 stated PPE equipment was located outside the door for residents on precautions that protect the resident from staff, so that staff did not get the resident sick or give them germs if they have an open wound or a catheter. She said if the resident was on this type of precautions, the resident had a sign on their door that said what PPE staff needed to wear when providing care. She explained this type of precaution was called EBP and there would be a yellow sign on the resident's door if they were on EBP. NA #3 said there was not a sign on Resident #19's door for EBP. NA #3 said she was told by the Assistant Director of Nursing (ADON), Director of Nursing (DON), and administration EBP were only used if a resident had a wound or an indwelling catheter. She explained with EBP she needed to wear PPE indicated on the sign if she was doing direct care with a resident. NA #3 said direct care would be dressing, changing, getting up, giving showers, providing catheter care, or any care where she would be touching the resident in some sort of way. An interview was performed on 05/02/24 at 09:26 AM with NA #2. She said when Resident #19 returned from dialysis she was weak and sometimes required two staff members to help transfer her from her wheelchair to her bed. NA #2 stated she helped Resident #19 with her showers and would put a plastic bag over her dialysis catheter and tape it in place to keep the dialysis catheter dry during showers. She stated she had received education on EBP but had never been told that she needed to use EBP when providing care to Resident #19. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was performed on 4/30/24 at 1:22 PM with the ADON. She stated staff would know if a resident was on precautions and what type of PPE they needed to use by the precautions sign located on the resident's door. She stated EBP were used for residents with chronic big wounds, not small wounds or if a resident has an indwelling device like a catheter or PICC line. The ADON stated she had thought about adding EBP for Resident #19 because she had a dialysis catheter. She said she had decided not to place Resident #19 on EBP because her Permacath dressing was changed at dialysis, and she thought Resident #19 was pretty independent with her care and did not need much assistance from the NAs. She said if Resident #19's Permacath dressing started to peel up or came off between dialysis days the nurse would either reinforce or change the dressing, she said staff would need to wear a gown and gloves if performing Permacath dressing care. She said she thought staff would know they needed to wear a gown when performing dressing care but was not sure if all staff would know or how staff would know they needed to wear a gown if Resident #19 did not have a sign on her door. The ADON stated she had not thought about Resident #19 being weak and tired when she returned from dialysis treatments and needing more care assistance, or staff reinforcing the Permacath dressing. She said she understood where staff may need to provide Resident #19 assistance with transfers and ADLs when she was weak and tired after dialysis and that she should be on EBP. She stated staff had been provided education on EBP but needed more education on EBP and what devices required EBP. 05/01/24 03:58 PM Interview was performed with the DON. She stated the facility had not placed Resident #19 on EBP because Resident #19's Permacath dressing was changed by the dialysis center and Resident #19 was pretty independent. However, she stated if staff had to reinforce the dressing or had to assist Resident #19 with care when she was weak after dialysis then Resident #19 should have been on EBP. An interview was performed with the Medical Director on 5/1/24 1:49 PM. The Medical Director stated residents who required EBP should have them in place including Resident #19. An interview was conducted on 05/02/24 at 10:45 AM with the Administrator. He Stated residents with indwelling devices should be on EBP. He stated he thought Resident #19 was not put on EBP because the facility staff do not use the dialysis catheter or access it, it did not flag in their mind that she needed EBP.

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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.