STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345119	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northchase Nursing and Rehabilitation Center	3015 Enterprise Drive Wilmington, NC 28405

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 32968 Based on record review, staff interviews, and Nurse Practitioner (NP) interview the facility failed to notify the provider of significant weight gain greater than 3-pounds (lbs.) in 24-hours (hrs.), or 5-lbs. in a week, for a resident that required weight gain monitoring for possible cardiac fluid overload due to resident's history of Congestive Heart Failure (CHF). This deficient practice occurred for 1 of 11 sampled residents reviewed for notification of change. (Resident #20) Findings included: Resident #20 was admitted on [DATE]. His medical diagnoses included Congestive Heart Failure (CHF). A physician order written to start on 05/01/24 revealed daily weights times 2-weeks and notify provider of 3-lb. weight gain in 24-hours or 5-lbs. in a week, then weekly during day shift for CHF for 14-days, with start day 05/01/24. Review of Resident #20's Medical Administration Record (MAR) dated 05/01/24 through 05/14/24 revealed to obtain daily weights and report weight gain greater than 3-lbs. in 24-hours or 5-lbs. in a week (started 05/01/24). Recorded weights in Resident #20's MAR were recorded daily and signed off as completed as evidenced by nursing initials and a check mark daily up to 05/14/24. Review of Resident #20's daily weight: On 05/06/24 was 182.5 lbs. and his daily weight on 05/07/24 was 190-lbs. a weight gain of 7.5-lbs. in 1-day. On 05/09/24 was 189-lbs. and his daily weight on 05/10/24 was 191-lbs. a weight gain of 3-lbs. in 1-day. On 05/11/24 was 184-lbs. and his daily weight on 05/14/24 was 189. 3-lbs. a weight gain of 5.3-lbs. in 3-days. Further review of the medical record for Resident #20 revealed there was no evidence the physician was notified of weight changes as ordered. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 05/16/24 3:20 PM with the Nurse Practitioner (NP). The NP stated this was the first time she or MD had heard of Resident #20's one day weight gain of 7.5-pound from 05/06/24 through 05/07/24, and the three-day weight gain of 5.3-lbs. from 05/11/24 through 05/14/24, or the other 3 lb. one day weight gain 05/09/24 through 05/10/24. She stated no staff had reported to her any weight concerns. The NP expected the MD to be notified if Resident #20's daily weights were greater than 3-lbs. in one day or 5-lbs. in a week related to resident having a diagnosis of CHF. NP said she was not made aware or notified by nursing staff of resident's weight gain and should have. NP said Resident #20's weight gains had no health outcome, but could have, and she expected the MD to have been notified, per order, to treat the weight gain to determine if related to CHF, and if additional medication needed to be ordered or change in treatment adjusted. An interview on 05/16/24 at 4:30 PM with the Director of Nursing (DON) revealed it was her expectation that Resident #20's MD should have been notified of resident's greater than 3-lb. weight gain in a day or 5-lb. weight gain in a week, per physician's order. She said she did not know why the MD was not notified and should have per MD order.

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32968 Based on record review and staff interviews the facility failed to provide a Centers for Medicare and Medicaid Services (CMS) Skilled Nursing Facility Advanced Beneficiary Notice (SNF-ABN) prior to discharge from Medicare Part A skilled services for 2 of 3 residents reviewed for beneficiary protection notification who required the provision of the SNF-ABN form (Resident #126 and #129). Findings included: a. Resident #126 was admitted to the facility on [DATE]. Review of Beneficiary Notices - Residents discharged Within the Last Six Months form revealed Resident #126 Medicare Part A skilled services ended on 01/29/24. She remained in the facility with benefit days remaining, per Notice of Medicare Non-Coverage (NOMNC, Form CMS-10123). Record review revealed that Resident #126 was not given the CMS-10555 Skilled Nursing Facility Advanced Beneficiary Notice (SNF-ABN). b. Resident #129 was admitted to the facility on [DATE]. Review of Beneficiary Notices - Residents discharged Within the Last Six Months form revealed Resident #129 Medicare Part A skilled services ended on 02/12/24. She remained in the facility with benefit days remaining, per Notice of Medicare Non-Coverage (NOMNC, Form CMS-10123). Record review revealed that Resident #129 was not given the CMS-10555 Skilled Nursing Facility Advanced Beneficiary Notice (SNF-ABN). An interview was conducted on 05/15/24 at 11:50 AM with the Social Services Director (SW#1). The SW #1 indicated she or SW #2, who was new, should have provided Residents #126 and #129 with the CMS-10555 Skilled Nursing Facility Advanced Beneficiary Notice (SNF-ABN) form, but was unable to provide documentation that they were provided. An interview was conducted on 05/16/2024 at 2:00 PM with the Administrator and she revealed it was her expectation that the residents at the facility or Responsible Party (RP) should be provided appropriate notices prior to being discharged from Medicare.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45711 Based on record review and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessments accurately in the area of nutrition for 4 of 11 residents whose MDS assessments were reviewed for nutrition (Residents #107, #12, #19, # 69). Findings included: 1. Resident #107 was admitted on [DATE] with diagnosis which included adult failure to thrive and diabetes. Review of Resident #107's electronic health record revealed the following weights were recorded: 10/2/2023- 207.3 pounds (Lbs.) 11/10/2023- 205.1 Lbs. 12/5/2023- 194.2 Lbs. 1/19/2024- 181.8 Lbs. 1/30/2024- 177.1 Lbs. 2/9/2024- 172.5 Lbs. 3/26/2024- 147.6 Lbs. 4/2/2024 1:14 PM- 152.3 Lbs. 4/10/2024 2:35 PM- 158.1 Lbs. Review of Resident #107's weights recorded revealed resident had a 47.1-pound weight loss in180 days (22.92 percent). Review of Resident #107's 4/12/24 quarterly Minimum Data Set (MDS) indicated resident had a mild cognitive impairment. Resident #107's weight was 158 pounds and resident was coded as had no weight loss or weight gain of 5 percent in the past 30 days or 10 percent in the past 180 days. An interview was conducted on 5/16/24 at 3:15 PM with MDS Coordinator #1. MDS Coordinator #1 stated the MDS Coordinator was responsible for the completion of the nutrition section of the MDS assessments. MDS Coordinator #1 stated Resident #107's 4/12/24 quarterly MDS should have been coded for a significant weight change. MDS Coordinator #1 further revealed the computer usually gave a warning when a resident had a significant weight change but it had not been giving the warnings so that may have contributed to the error. MDS Coordinator #1 indicated she was aware of how to calculate a weight change per the Resident Assessment Instrument (RAI) manual, but she had not done it. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 5/16/24 at 4:35 PM with the Director of Nursing (DON). The DON stated she expected that the MDS assessments would be coded accurately, that the weight changes would be calculated, and she did not know why the resident had lost weight. An interview was conducted on 5/17/24 at 1:50 PM with the Administrator. The Administrator stated she expected the MDS assessments to be completed accurately. The Administrator further stated it was important for the MDS assessments to be accurate for the resident care plans to be accurate and reflect the resident's current condition. 2. Resident #12 was admitted on [DATE] with diagnosis which included in part end stage renal disease. Review of Resident #12's electronic health record revealed the following weights were recorded: 9/28/23- 224 pounds (Lbs.) 2/27/24- 222.2 Lbs. 3/26/24- 199.1 Lbs. Review of Resident #12's weights recorded revealed resident had a 23-pound weight loss in 30 days (10. 4%) and 25-pound weight loss in 180 days (greater than 10%). Review of Resident #12's 3/26/24 quarterly Minimum Data Set (MDS) assessment revealed the resident had severe cognitive impairment. Resident #12 was coded as having a weight of 199 pounds with no weight loss or weight gain of 5 percent in the past 30 days or 10 percent in the past 180 days. An interview was conducted on 5/16/24 at 3:15 PM with MDS Coordinator #1. MDS Coordinator #1 stated the MDS Coordinator was responsible for the completion of the nutrition section of the MDS assessments and Resident #12's MDS should have been coded for a significant weight change. MDS Coordinator #1 revealed the computer usually gave a warning when a resident had a significant weight change but it had not been giving the warnings so that may have contributed to the error. MDS Coordinator #1 indicated she was aware of how to calculate a weight change per the Resident Assessment Instrument (RAI) manual but she had not done it. An interview was conducted on 5/16/24 at 4:35 PM with the Director of Nursing (DON). The DON stated she expected that the MDS assessments would be coded accurately. An interview was conducted on 5/17/24 at 1:50 PM with the Administrator. The Administrator stated she expected the MDS assessments to be completed accurately. The Administrator further stated it was important for the MDS assessments to be accurate for the resident care plans to be accurate and reflect the resident's current condition. 3. Resident #19 was admitted to the facility on [DATE] with diagnosis which included diabetes and hypertension. Review of Resident #19's electronic health record revealed the following weights were recorded: (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11/29/2023- 156.5 pounds (Lbs.) 12/1/2023- 156.5 Lbs. 12/5/2023- 150.7 Lbs. 12/12/2023- 148.4 Lbs. 12/21/2023- 143.7 Lbs. 12/29/2023- 143.0 Lbs. 1/11/2024- 147.3 Lbs. 1/30/2024- 142.2 Lbs. 2/9/2024- 140.0 Lbs. 3/7/2024- 141.6 Lbs. 3/12/2024- 135.0 Lbs. 4/9/2024- 178.0 Lbs. 4/9/2024 incorrect documentation 4/9/2024- 178.0 Lbs. Review of Resident #19's weight record revealed resident had a 43-pound weight gain in 30 days (24.16 percent) and a 21.5-pound weight gain in 180 days (13.74 percent). Review of Resident #19's quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated resident was coded as had a weight of 178 pounds. The MDS assessment indicated Resident #19 had no weight loss or weight gain of 5 percent in 30 days or 10 percent in 180 days. An interview was conducted on 5/16/24 at 3:15 PM with MDS Coordinator #1. MDS Coordinator #1 stated the MDS Coordinator was responsible for the completion of the nutrition section of the MDS assessments. MDS Coordinator #1 stated Resident #19's 4/11/24 quarterly MDS should have been coded for a significant weight change. MDS Coordinator #1 further revealed the computer usually gave a warning when a resident had a significant weight change but it had not been giving the warnings so that may have contributed to the error. MDS Coordinator #1 indicated she was aware of how to calculate a weight change per the Resident Assessment Instrument (RAI) manual. MDS Coordinator #1 stated she had not calculated the weight change and the computer populated the assessment with the weight, so she had not checked it. MDS #1 stated maybe she should have questioned the weight that entered on Resident #19's assessment and reviewed the weights more carefully. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 5/16/24 at 4:35 PM with the Director of Nursing (DON). The DON stated she expected that the MDS assessments would be coded accurately, and the weight change would be calculated. An interview was conducted on 5/17/24 at 1:50 PM with the Administrator. The Administrator stated she expected the MDS assessments to be completed accurately. The Administrator further stated it was important for the MDS assessments to be accurate for the resident care plans to be accurate and reflect the resident's current condition. 37673 4. Resident #69 was admitted to the facility on [DATE] with diagnoses that included: End stage renal disease, mild protein calorie malnutrition, dependence on renal dialysis, and Type 2 Diabetes Mellitus. Review of the MDS assessment for Resident #69 dated 03/29/24 documented he had intact cognition. He weighed 169 pounds. He had no weight gain in six months. Review of the recorded weights for Resident #69 revealed he weighed 135.3 pounds on 09/29/23 and 169 pounds on 03/29/24 showing a weight gain of 24.91 percent. In an interview with the DON and the Administrator on 05/16/24 at 8:45 AM they both stated they expected the MDS assessment to be coded correctly to reflect that Resident #69 had a weight gain during the six month assessment look back period. In an interview with MDS Nurse #1 on 05/16/24 at 13:51 PM she stated the MDS assessment dated [DATE] was coded incorrectly documenting the resident did not have a 10% or more weight gain in the previous six months because he did have a weight gain of 24.91 percent during this period. She did not know why the assessment had been coded incorrectly.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45711 Based on record review, and staff and resident interviews, the facility failed to update the comprehensive care plan to reflect changes in care interventions in the areas of mobility and nutrition. This was for 3 of 11 residents whose care plans were reviewed (Resident #107, Resident #12, and Resident #19). Findings included: 1.Resident #107 was admitted on [DATE] with diagnosis which included: stroke with hemiparesis, adult failure to thrive and diabetes. a. Review of Resident #107's nutrition care plan last revised on 1/31/2024 revealed a problem of state of nourishment more than body requirement characterized by weight gain, obesity, excessive appetite related to: increased caloric and fat intake, and sedentary lifestyle. The goal indicated the resident would adhere to a prescribed diet, would eat food only from their own plate, and would eliminate snacking between meals. The care plan did not include a goal of a desired weight to be achieved. Interventions included avoiding using food as a reward, using other means of positive encouragement, and referring to the dietitian for evaluation/recommendations. Review of Resident #107's record revealed the following weights and physician orders were recorded: 10/2/23- 207.3 pounds (lb.) 11/10/23-205.1 lb. 12/5/23- 194.2 lb. 1/19/24- 181.8 lb. 1/26/2024 a physician order was written for [brand name] nutritional supplement three times per day with meals and regular diet with enriched meals for Resident #107 due to weight loss. 1/30/24- 177.1 lb. 2/9/24- 172.5 lb. 3/26/24- 147.6 lb. 3/26/24 a physician order for Resident #107 to have weekly weights measured. 4/2/24- 152.3 lb. 4/10/24- 158.1 lb. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #107's quarterly Minimum Data Set (MDS) dated [DATE] noted her weight was 158 pounds and had no weight loss or weight gain. An interview was conducted on 5/15/24 at 11:30 AM with the Registered Dietitian (RD). The RD revealed she was in the position since January 2024, her role was to complete a clinical review of the nutritional status of the residents, and she was not involved in the care planning process. The RD stated she was aware Resident #107 was not eating well and had lost a significant amount of weight. An interview was conducted on 5/16/24 at 3:10 PM with MDS Coordinator #1. MDS Coordinator #1 stated she was responsible for updating resident care plans and it was an error that Resident #107's care plan was not revised to reflect the weight loss and current interventions. She explained this had been an oversight. An interview was conducted on 5/17/24 at 1:50 PM with the Administrator. The Administrator stated she expected the care plans would be accurate and up to date, including current information and interventions. b. Review of Resident #107's quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated she had impaired range of motion of the upper and lower extremities on one side, required extensive assistance with transfers, was noted as dependent for wheelchair mobility, and walking was coded as not applicable. A review of Resident #107's mobility care plan last reviewed on 4/26/24, included a focus of requires assistance for potential to restore or maintain maximum function of self-sufficiency for mobility characterized by the following functions: positioning, locomotion and ambulation related to at risk for limitation of range of motion in upper and lower extremities. The goal indicated resident will walk 50 feet with a hemi walker (a walker for a resident with the use of only 1 hand or arm) and left ankle brace through next review. Interventions included providing verbal cues and minimal assist of 1 person for ambulation of 50 feet with hemi walker and left ankle brace. An interview on 5/16/24 at 10:15 AM with the Rehabilitation Director revealed Resident #107 last received therapy from January 2024 through April 2024 to address mobility, positioning, and transfers. The Rehabilitation Director stated Resident #107 was non-compliant with splints, was non-ambulatory, and did not progress well with therapy. An interview was conducted on 5/16/24 at 3:10 PM with MDS Coordinator #1. MDS Coordinator #1 stated she was responsible for updating resident care plans and it was an error that Resident #107's care plan was not revised to reflect her current non ambulatory status. She explained this had been an oversight. An interview was conducted on 5/17/24 at 9:35 AM with Nurse #1. Nurse #1 indicated she was assigned to Resident #107 frequently and was familiar with her care. She explained Resident #107 had not walked or worn a leg brace for a long time. An interview was conducted on 5/17/24 at 1:50 PM with the Administrator. The Administrator stated she expected the resident care plans to be revised to reflect changes in condition and interventions. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident #12 was admitted on [DATE]. Resident's diagnoses included in part end stage renal disease and dependence on renal dialysis. Review of Resident #12's nutrition care plan last revised on 1/24/23 indicated a problem for state of nourishment related to diagnosis of obesity, diabetes mellitus, increased protein needs and on therapeutic diet. Interventions indicated cardiac diet, regular texture, supplement as ordered, monitor weight, and notify physician as indicated. The resident had actual weight loss, received a renal carbohydrate-controlled diet and was on dialysis which was not updated/included in this nutrition care plan. Review of Resident #12's record revealed the following weights were recorded: 9/28/23- 224 pounds (lb.) 2/27/24- 222.2 lb. 3/26/24- 199.1 lb. Review of the weights recorded revealed resident had a 23-pound weight loss in 30 days (10.4%) and 25-pound weight loss in 180 days (greater than 10%). Review of Resident #12's 3/26/24 quarterly Minimum Data Set (MDS) assessment revealed Resident #12 was coded as having a weight of 199 pounds with no weight loss or weight gain and received a therapeutic diet. Review of Resident #12's record revealed a physician order dated 3/29/24 for renal carbohydrate-controlled diet regular texture. Review of Resident #12's record revealed a 4/19/24 Registered Dietitian (RD) progress note which indicated resident's nutritional status was reviewed due to dialysis. The note indicated resident received a renal carbohydrate-controlled diet with regular texture and thin liquids and had a weight decrease of 14.5# (6.7 percent) over 30 days. An interview was conducted on 5/15/24 at 11:05 AM with the Registered Dietitian (RD). The RD stated she had been in the position since January 2024 and was following Resident #12 regarding the significant weight change. The RD stated she was not involved with the resident care plans. An interview was conducted on 5/16/24 at 3:10 PM with MDS Coordinator #1. MDS Coordinator #1 stated she was responsible for updating resident care plans and it was an error that Resident #12's care plan was not revised to reflect her current nutritional status. She explained this had been an oversight. An interview was conducted on 5/17/24 at 1:50 PM with the Administrator. The Administrator stated she expected the resident care plans would be accurate, person centered and revised as needed. 3. Resident #19 was admitted to the facility on [DATE] with diagnosis which included diabetes. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #19's record revealed the following weights were recorded: 11/29/2023- 156.5 pounds (lb.) 12/5/23- 150.7 lb. Review of Resident #19's current nutrition care plan indicated a problem last revised on 12/11/23 which indicated state of nourishment more than body requirement characterized by weight gain, obesity, excessive appetite related to overweight, diabetes, and heart disease. The goals indicated Resident #19 would adhere to the prescribed diet, would eat food only from her own plate, would eliminate snacking between meals and total intake would meet resident's nutritional needs as evidenced by weight stability. Interventions included avoiding using food as a reward, using other means of positive reinforcement, consistent carbohydrate/no added salt diet, regular texture, refer to dietitian for evaluation/recommendations, and weigh per facility protocol. Review of Resident #19's record revealed the following weights were recorded: 12/12/23- 148.4 lb. 1/11/24- 147.3 lb. 2/9/24- 140.0 lb. 3/7/24- 141.6 lb. 3/12/24- 135.0 lb. 4/9/24- 178.0 lb. A 4/12/24 physician order indicated Resident #19 received a consistent carbohydrate diet pureed texture with nectar consistency liquids. Review of Resident #19's quarterly Minimum Data Set (MDS) assessment dated [DATE] noted a weight of 178 pounds with no weight loss or weight gain and they received a mechanically altered diet. A review of Resident #19's electronic health record revealed a 4/11/24 physician order for daily weights for 2 weeks then weekly due to 43-pound weight gain in 1 month. 4/12/24- 138.4 lb. 4/19/24- 132.4 lb. A 4/19/24 physician order indicated Resident #19 was to receive [brand name] nutritional supplement one time a day for additional calories and protein and a regular diet. 5/14/24- 129.7 lb. (continued on next page)

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A 5/14/24 Nurse Practitioner progress note indicated Resident #19 was evaluated due to unintentional weight loss. The note indicated Resident #19's diet was advanced to regular diet to increase intake. An interview was conducted with the Registered Dietitian (RD) on 5/15/24 at 11:10 AM. The RD stated she was in the position since January 2024, her role was to complete clinical reviews of the residents' nutrition and she was not involved in the care planning process. The RD indicated Resident #19 had significant weight loss. An interview was conducted on 5/16/24 at 3:10 PM with MDS Coordinator #1. MDS Coordinator #1 stated it was an error that Resident #19's care plan was not updated regarding the weight loss and current interventions. She explained she was responsible for the completion of the nutrition focus in the care plan and Resident #19's care plan should have been revised when she began losing weight. MDS Coordinator #1 also explained that the previous RD who left in December updated and revised the nutrition care plans but the new RD did not. An interview was conducted on 5/17/24 at 1:50 PM with the Administrator. The Administrator stated she expected the resident care plans would be accurate and revised to reflect changes in condition and interventions.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32968 Based on observations, record review, resident and staff interviews the facility failed to provide tray set-up and assistance with eating to maintain resident's ability to feed themselves for 3 of 3 residents (Resident #112, #126, and #131) reviewed for activities of daily living (ADL). The findings included: 1. Resident #112 was admitted [DATE] with diagnoses that included: dysphagia, dementia, and mild protein calorie malnutrition. Resident #112 was receiving palliative care through hospice services. The resident's Quarterly Minimum Data Set (MDS) dated [DATE] indicated the resident had moderate to severe cognitive impairments and required supervision and set up only for meals during the assessment period. Resident #112's care plan dated 03/26/24 revealed a potential for fluid volume deficit related to anemia, with nourishment less than body requirement, inadequate intake, and decreased appetite. A nursing note dated 05/10/24 at 10:41 AM for Resident #112 revealed the resident had triggered a 110% weight loss over the last 180-days. The Resident's Health Care Provider and Responsible Party (RP) was notified with no new orders at that time. The resident continued Hospice services and continued to receive Med-Pass (a nutritional supplement) 120 mL by mouth twice per day, and enriched meals with staff encouragement. A Registered Dietitian (RD) note dated 05/10/24 at 1:37 PM for Resident #112 revealed the resident continued to receive hospice care, with mechanical soft texture diet and thin liquids. Her by mouth intake reflects 50-75%, occasionally more, with added med-pass supplement two times per day. An interview and observation were conducted on 05/14/24 at 8:45 AM with Resident #112. She said her breakfast tray was not set up and should have been. She was observed trying to punch a hole into her juice container with a plastic straw and failed to puncture the aluminum lid and dropping the broken straw onto the floor. She said with only one hand she was not able to open her mighty shake, milk carton, or juice, or cut her sausage or French toast. An interview was conducted on 05/14/24 at 9:15 AM with the Rehabilitation Director. She said all resident meal trays should be set-up by facility staff if the residents were not independent. She said Resident #112 was in Hospice and needed tray set-up assistance with meals. On 05/14/24 at 12:40 PM Resident #112 was observed sitting up in bed with her lunch tray in front of her. The Nursing Aide (NA) was not present. Resident #112 made several attempts to put a straw in the lid of a juice cup and was unsuccessful. She was observed trying to grasp and open her milk carton with her fingers and failed. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 05/15/24 at 11:30 AM with the Registered Dietitian. She said all residents' meal trays should be set up unless they specifically requested to set-up their meal tray themselves. An interview was conducted on 05/15/24 at 2:06 PM with the Director of Nursing. She said all residents who needed partial/moderate assistance with meals means tray set-up and additional help if needed. She further stated Residents' meal trays should be set up unless they specifically requested to set-up their meal tray themselves. An interview was conducted on 05/16/24 at 3:20 PM with the Nurse Practitioner. She expected most of the resident meal trays to be set up by the NAs, unless the resident specifically requested to set-up their own meal tray. She said it is good nursing practice to do so, by improving meal intake, encouraging eating, and by getting to know residents likes and dislikes, and time to offer alternates. An interview was conducted on 05/17/24 at 9:45 AM with Nursing Aide (NA#2). NA#2 stated, she only worked part-time and could not remember which residents on the 500-hall (the hall where Resident #112 resided) needed their meal trays to be set-up or not. She was not aware Resident #112 received assistance with her meals. She said she rarely worked on the 500-hall and wasn't told which residents needed meal tray set-up or assistance with feeding. She said she could not remember anything about that day. 2. Resident #126 was admitted to the facility on [DATE] with diagnoses that included diabetes, congestive heart disease, adult failure to thrive, and anemia. Resident #126's Minimum Data Set (MDS) dated [DATE] revealed resident had had no cognitive impairments and needed supervision with eating. Resident #126's care plan dated 04/30/24 revealed: Potential for or Actual fluid volume deficit due to: 1500ml fluid restriction, daily diuretic use. State of nourishment; more than body requirement characterized by weight gain. Ms. [NAME] required assistance with the activities of Daily Living/Personal Care due to weakness, adult failure to thrive and congestive heart failure. Interventions included: Eating (oral intake): Set-up/clean-up assistance. An interview and observation were conducted on 05/14/24 at 8:50 AM with Resident #126. She said her breakfast tray was not set up and should have been. She was observed holding up a fork with a round sausage patty stuck to the end, eating around the edges of the sausage. She was also observed not able to open her milk or juice container and was unable to use the knife and fork together to cut her French toast into smaller pieces which would have been easier to eat. An interview was conducted on 05/14/24 at 9:15 AM with the Rehabilitation Director. She said all resident meal trays should be set-up by facility staff if the residents were not independent. She said Resident #126 was receiving Physical Therapy (PT) in her room and needed tray set-up assistance with meals. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 05/17/24 at 9:45 AM with Nursing Aide (NA#2). NA#2 stated, she only worked part-time and could not remember which residents on the 500-hall (the hall where Resident #126) needed their meal trays to be set-up or not. She was not aware #126 received assistance with her meals. She said she rarely worked on the 500-hall and wasn't told which residents needed meal tray set-up or assistance with feeding. She said she could not remember anything about that day. 3. Resident #131 was admitted [DATE] with diagnoses that included hemiplegia, dysphagia, cerebral infarction (stroke), and diabetes. The resident's Minimum Data Set (MDS) dated [DATE] indicated the resident had no cognitive impairments and needed supervision with eating. Resident #131's care plan dated 04/08/24 revealed a potential for fluid volume deficit related to anemia, with nourishment less than body requirement, inadequate intake, and decreased appetite. Interventions included: Provide assistance with meal as indicated, with set-up/clean-up assistance, due to hemiplegia/hemiparesis following cerebral infarction affecting left non-dominant side. An interview was conducted on 05/14/24 at 8:15 AM with Resident #131. She said her breakfast tray was not set up and should have been. She said with only one hand she was not able to open her mighty shake, milk carton, or juice, or cut her sausage or French toast. An interview was conducted on 05/14/24 at 8:30 AM with Nurse #3. She said Resident #131 could only use her right hand due to a stroke and needed Nursing Aides (NAs) to set-up her tray and assist with her meals. The nurse said she did not know why the NAs did not set up Resident #131 meal tray.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40044 Based on observations, record review, staff, and the Nurse Practitioner interviews the facility failed to 1.) obtain blood pressure readings or heart rate prior to administering the antihypertensive medication Metoprolol which had parameters to hold the medication if the systolic blood pressure was less than 110 mmHg (millimeters of mercury) or heart rate less than 60 beats per minute. (Resident #17) and 2.) obtain physician ordered weekly weights for a resident with congestive heart failure. (Resident #44). This occurred for 2 of 2 residents (Resident #17, Resident #44) reviewed for quality of care. Findings included. 1.) Resident #17 was admitted to the facility on [DATE] with diagnoses including hypertension, and end stage renal disease. A care plan dated 02/10/23 with a target date of 06/18/24 revealed Resident #17 had end stage renal disease, received hemodialysis and was at risk for complications. Interventions included to monitor vital signs. A physician's order dated 04/02/24 for Resident #17 revealed Metoprolol Succinate extended release 50 milligrams (mgs). Give one tablet by mouth daily for hypertension. Hold for systolic blood pressure less than 110 mmHg or heart rate less than 60 beats per minute. Review of Resident #17's Medication Administration Record (MAR) dated April 2024 revealed Metoprolol Succinate extended release 50 milligrams was scheduled for administration daily at 8:00 AM. The medication was signed as administered on the following dates with no corresponding blood pressure or heart rate recorded. 04/19/24 at 8:00 AM with no blood pressure or heart rate recorded. 04/20/24 at 8:00 AM with no blood pressure or heart rate recorded. 04/21/24 at 8:00 AM with no blood pressure or heart rate recorded. 04/22/24 at 8:00 AM with no blood pressure or heart rate recorded. 04/24/24 at 8:00 AM with no blood pressure or heart rate recorded. 04/26/24 at 8:00 AM with no blood pressure or heart rate recorded. 04/28/24 at 8:00 AM with no blood pressure or heart rate recorded. 04/29/24 at 8:00 AM with no blood pressure or heart rate recorded. Review of Resident #17's progress notes dated 04/19/24 through 04/29/24 revealed no blood pressure or heart rate recordings that corresponded to the Metoprolol administration time. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #17's Medication Administration Record (MAR) dated May 2024 revealed Metoprolol Succinate extended release 50 milligrams was scheduled for administration daily at 8:00 AM. The medication was signed as administered on the following dates with no corresponding blood pressure or heart rate recorded. 05/03/24 at 8:00 AM with no blood pressure or heart rate recorded. 05/04/24 at 8:00 AM with no blood pressure or heart rate recorded. 05/05/24 at 8:00 AM with no blood pressure or heart rate recorded. 05/08/24 at 8:00 AM with no blood pressure or heart rate recorded. 05/10/24 at 8:00 AM with no blood pressure or heart rate recorded. 05/12/24 at 8:00 AM with no blood pressure or heart rate recorded. Review of Resident #17's progress notes dated 05/03/24 through 05/12/24 revealed no blood pressure or heart rate recordings that corresponded to the Metoprolol administration time. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #17 had moderately impaired cognition. She had no rejection of care and received hemodialysis. A progress note documented by the Nurse Practitioner dated 05/15/24 revealed in part; Resident #17 was alert and oriented to person, place, and time. She was sitting in her wheelchair at the nurses station in no distress. She was appropriate and not drowsy. Her blood pressure was 116/76 (systolic/diastolic), pulse rate was 88 beats per minute. The cardiovascular exam indicated Resident #17 was at her baseline. During an interview on 05/17/24 at 12:45 PM Resident #17 was observed in her wheelchair in the hallway. She was alert and oriented to person, place, and time. She was pleasant and easily engaged in conversation. She stated she was doing okay today and voiced no concerns. She indicated that she had no concerns with her medications and was not aware of the times her medications were scheduled for administration. During an interview on 05/17/24 at 2:00 PM the Director of Nursing stated Nurse #4 and Nurse #5 who administered the Metoprolol on the dates with no blood pressures or heart rate recorded were not available for interview. She stated Nurse #4 was away on vacation and she made attempts today to contact Nurse #5 and there was no response. She stated the Medical Director was unavailable for interview due to a family emergency. She indicated a blood pressure and heart rate should have been obtained and recorded prior to administering the Metoprolol. She acknowledged there were no corresponding blood pressures and heart rate recorded in Resident #17's medical record during the time the medication was administered for the dates listed. She indicated education would be provided to nursing staff regarding medication administration and monitoring blood pressures and heart rate. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a phone interview on 05/17/24 at 3:30 PM the Nurse Practitioner stated she routinely evaluated Resident #17 and last examined her on 05/15/24. She indicated she was not aware that Resident #17 was not having her blood pressure taken prior to Metoprolol administration. She stated the Metoprolol was prescribed to Resident #17 to control high blood pressure and her blood pressure reading on 05/15/24 was 116/76 (systolic/diastolic). She stated her blood pressures have been okay. She indicated Resident #17 received hemodialysis and her blood pressures fluctuated at times which was why parameters were in place to hold the medication if the blood pressure or heart rate was low. She stated there had been no reports to her regarding a change of condition and blood pressures and heart rate should be obtained prior to administering the medication. 2.) Resident #44 was admitted to the facility on [DATE] with diagnoses including congestive heart failure. A physician's order dated 02/16/24 for Resident #44 revealed Furosemide (diuretic) 40 milligrams (mgs). Give one tablet by mouth daily for congestive heart failure. A physician's order dated 02/16/24 for Resident #44 revealed Aldactone (a potassium sparing diuretic) 25 milligrams (mgs). Give one tablet by mouth daily for hypertension. The Minimum Data Set (MDS) admission assessment dated [DATE] revealed Resident #44 was cognitively intact. She had no rejection of care. A physician's order dated 03/20/24 for Resident #44 revealed to obtain weekly weights for congestive heart failure. Review of Resident #44's electronic medical record from 03/20/24 through 05/17/24 revealed the following weights recorded: 03/27/24 the recorded weight was 196.1 Lbs. (pounds) 04/02/24 the recorded weight was 201.5 Lbs. 04/23/24 the recorded weight was 202.5 Lbs. 05/14/24 the recorded weight was 207.0 Lbs. During an interview on 05/17/24 at 1:23 PM the Nurse Practitioner stated she was not aware Resident #44 was not getting weekly weights according to the order. She stated weekly weights were ordered to monitor fluid retention due to congestive heart failure. She stated Resident #44 had no change in condition and she expected weekly weights to get done according to the order. During an interview on 05/17/24 at 1:48 PM Resident #44 was observed sitting in her wheelchair. She was alert, and oriented to person, place, and time. She stated weekly weights have not been done, but she did get weighed 2 or 3 days ago. She stated she did not refuse care and wanted her weight monitored. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/17/24 at 2:00 PM the Director of Nursing stated upon reviewing Resident #44's Medication Administration Record (MAR) the order for weekly weights was on the MAR but it had an x on the MAR each day and therefore it would not populate on the MAR to obtain a weekly weight. She indicated the error was due to the way the order was entered into the electronic medical record that prevented it from populating on the MAR to obtain the weight weekly. She indicated if it had shown on the MAR the nurse would have informed a nurse aide to obtain the weight. She stated it would be corrected immediately. She stated Resident #44 was weighed on 05/14/24 and was evaluated by the Registered Dietician on 05/15/24. She stated she expected weight orders to be entered into the electronic medical record correctly and education to nursing staff would be provided.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45711 Based on record review, observation, and resident, staff and Nurse Practitioner interviews, the facility failed to obtain an appointment with an ophthalmologist for evaluation of vision for 1 of 1 resident (Resident # 22) reviewed for vision. Findings included: Resident # 22 was admitted to the facility on [DATE]. Resident #22's medical diagnoses included cataracts and diabetes. Review of the facility grievance log revealed a grievance form dated 12/4/23 completed by Resident #22 was received by the Director of Nursing (DON) and the Assistant Administrator. The grievance was regarding Resident #22's request for a referral to an eye doctor for cataracts. Resident #22 stated the request had previously been made to the hall nurse. The outcome was that referrals and appointments were to be made. Findings of the grievance indicated that the DON stated Resident #22 sees the in-house eye care provider for her eye care and was last seen on 12/6/22. The grievance indicated an annual visit was tentatively scheduled for January 2024. The grievance further indicated Resident #22 would be placed on the list for the next in- house eye care visit. If the resident did not want to wait for the in-house provider, the grievance indicated will discuss an outside referral with the provider. The grievance resolution was issued to the resident on 12/6/23. Review of a 12/6/23 letter addressed to Resident #22 indicated resident requested a referral to see an eye doctor. The letter stated after an appropriate investigation supervised by the grievance official, it was determined that the resident sees the in-house eye care provider for eye care for annual eye exams. The letter indicated the resident would be informed of the next visit with the eye care company. Review of a 2/14/24 physician progress note revealed Resident #22 was evaluated and requested an ophthalmologist appointment regarding cataracts. The physician progress note indicated an order was written for referral to an ophthalmologist. Review of Resident #22's 2/14/24 physician orders revealed an order for follow up with ophthalmology regarding cataracts. Resident #22's quarterly Minimum Data Set (MDS) dated [DATE] indicated the resident was cognitively intact, had impaired vision and did not have glasses. Review of Resident #22's electronic health record revealed a 2/26/24 Nurse Practitioner progress note which indicated the resident required a referral for ophthalmology. The progress note indicated an order was written for the referral. Review of Resident #22's Nurse Practitioner progress note dated 3/7/24 indicated resident was asking about the ophthalmology appointment which was previously requested. The progress note indicated awaiting the scheduling of the ordered appointment. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #22's care plan revealed a focus last revised on 3/7/24 for impaired vision and risk for complications. The goal indicated Resident #22 would use compensatory mechanisms for decreased vision through next review. Interventions indicated ensure eyeglasses are clean, appropriate and being worn by resident, and obtain eye exam consultation for resident to ensure appropriate medications and compensatory mechanisms are in place. An interview was conducted on 5/13/24 at 12:04 PM with Resident #22. Resident #22 stated she still had not received an eye doctor appointment. Resident #22 stated she thought her eyesight was getting worse and she was concerned since she had a diagnosis of diabetes and cataracts. A following up interview was conducted on 5/16/24 at 12:26 PM with Resident #22. Resident #22 stated no one had talked to her this week about her request to see an ophthalmologist. Resident indicated the Social Worker had not talked to her. Resident stated she was concerned about obtaining the appointments as she had not seen the eye doctor in over a year. Resident #22 stated she filed a grievance in December and still had not received the requested appointment. An interview was conducted on 5/15/24 at 12:10 PM with the Transportation Specialist. The Transportation Specialist stated she was responsible for scheduling appointments and transportation for the residents. She stated she was in the position for the past year. The Transportation Specialist stated she was informed of referrals by the nursing staff, family members and the providers. The Transportation Specialist stated she had not made any appointments lately for Resident #22. She stated she was informed a while back that Resident #22 required an appointment with an ophthalmologist. The Transportation Specialist stated she was still working on arranging the appointment but had not recently tried. She stated when she had extra time, she called ophthalmologist offices to see if they would see the resident. She stated the last time she tried calling was a few weeks ago. The Transportation Specialist stated she did not have any notes indicating what offices she called, when and what the outcome was. The Transportation Specialist stated she was not sure how Resident #22 needed to be transported and it was difficult to obtain stretcher transportation. The Transportation Specialist stated she was not involved in the grievance that Resident #22 filed in December 2023 and was not made aware of the request to schedule the appointment in December 2023. An interview was conducted on 5/15/24 at 12:30 PM with Social Worker (SW) #1. SW#1 stated she had been in the position since December 2023. SW #1 stated she arranged the ophthalmologist visits with the in-house provider. SW #1 stated the last in-house ophthalmologist visit at the facility was in August 2023. Resident #22 was not seen in August 2023. SW #1 indicated Resident #22 was not seen by the in-house eye care provider since December 2022. SW #1 did not know why Resident #22 was not seen in August 2023. SW #1 stated the in-house eye care provider should be seeing residents at the facility in August 2024. SW #1 stated if a resident had a concern or needed to be seen by an ophthalmologist sooner than the annual visit, she could reach out to the company and request a visit to be arranged sooner. SW #1 stated she was not informed Resident #22 had a physician order for a referral in February 2024 to be seen by ophthalmology. SW #1 stated she went on maternity leave in February 2024, and she may have been gone when the referral was written in February. SW #1 stated she would talk to Resident #22 about obtaining a visit with the in-house ophthalmologist. An interview was conducted on 5/15/24 at 12:40 PM with Social Worker (SW) #2. SW #2 stated she was new to the position having started in January 2024. SW# 2 stated she was not notified of the physician order written in February 2024 for Resident #22 to see the ophthalmologist. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 5/15/24 at 1:45 PM with the Unit Manager. The Unit Manager stated she was not aware of a physician order for a referral for Resident #22 to see the ophthalmologist written by the provider in February 2023. The Unit Manager further stated she was not aware of a grievance that was filed by Resident #22 in December 2023 regarding her request to see an ophthalmologist. An interview was conducted on 5/16/24 at 3:30 PM with the Nurse Practitioner. The NP indicated a resident with a diagnosis of cataracts required evaluation at least annually. The NP stated the facility used a company that comes into the facility to provide ophthalmology care. The NP stated she expected to be notified if the facility did not complete a referral for an appointment. An interview was conducted on 5/17/24 at 4:30 PM with the Director of Nursing (DON). The DON stated they should have arranged the appointments for Resident #22 but there was a problem with the resident's payor source. An interview was conducted on 5/17/24 at 12:20 PM with the Administrator. The Administrator stated Resident #22 expressed a concern about having an ophthalmology appointment scheduled. The Administrator stated Resident #22 was not eligible to be seen by the in-house ophthalmologist that came in August 2023 since it wasn't a year since her last exam. The Administrator stated she guessed they could have tried to obtain the appointment with an outside provider. The Administrator stated there had been a delay in finding a provider that would accept the resident's insurance, but 5 months was a long time and maybe they could have tried to obtain the appointment sooner. The Administrator stated it was her understanding the only reason the resident wanted the appointment with the ophthalmologist was so she could see her iPad.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northchase Nursing and Rehabilitation Center	3015 Enterprise Drive Wilmington, NC 28405

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45711 Based on record review, observations and staff, resident and Nurse Practitioner interviews, the facility failed to provide physician ordered nutritional supplements on meal trays and failed to obtain physician ordered weights for 2 of 10 residents reviewed for nutrition (Resident #107 and Resident #19). 1.Resident #107 was admitted on [DATE]. Resident's medical diagnosis included stroke, failure to thrive, protein calorie malnutrition and diabetes. Review of Resident #107's electronic health record revealed the following weights were recorded: 10/2/2023- 207.3 pounds (Lbs.) 11/10/2023- 205.1 Lbs. 12/5/2023- 194.2 Lbs. 1/19/2024- 181.8 Lbs. 1/30/2024- 177.1 Lbs. 2/9/2024- 172.5 Lbs. 3/26/2024- 147.6 Lbs. 4/2/2024- 152.3 Lbs. 4/10/2024- 158.1 Lbs. 4/16/2024- 158.0 Lbs. 4/23/2024 No weight recorded. 4/30/2024 No weight recorded. 5/7/2024- 161.3 Lbs. 5/14/2024- 157.8 Lbs. Review of Resident #107's electronic health record revealed a 1/26/2024 physician order for Mighty Shake nutritional supplement three times per day with meals and regular diet with enriched meals. A 3/12/24 Nurse Practitioner (NP) progress note indicated resident continued with decreased appetite with stable decline in weight. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #107's electronic health record revealed a 3/26/2024 physician order for weekly weights. Review of Resident #107's 4/12/24 quarterly Minimum Data Set (MDS) indicated resident had a mild cognitive impairment. Resident #107's weight was 158 pounds and the resident was coded as had no weight loss or weight gain of 5 percent in past 30 days or 10 percent in past 180 days. A 4/24/24 NP progress note indicated resident was seen due to poor appetite and weight loss. The progress note indicated to continue with the enriched meal diet, nutritional supplement and encourage intake. The progress note did not indicate Resident #107 was receiving end of life care. Observation of Resident #107's lunch meal tray card on 5/13/24 at 12:40 PM revealed resident was to receive enriched meals, double vegetables, 2 bowls of soup, a peanut butter and jelly sandwich and a Mighty Shake nutritional supplement. The meal tray card further indicated disliked fish, spaghetti squash, zucchini, rice, pasta, and vegetables. Observation of the meal tray revealed Resident #107 did not receive double vegetables, soup, a sandwich, or a Mighty Shake nutritional supplement on the meal tray. Resident #107's meal tray consisted of 2 chicken tenders, a single serving of macaroni and cheese and a single serving of coleslaw. Observation of Resident #107's lunch meal tray on 5/14/24 at 12:40 PM revealed resident did not receive a Mighty Shake nutritional supplement on her meal tray. An interview was conducted on 5/14/24 at 12:45 PM with Resident #107. Resident #107 stated she did not receive a milk shake on her meal tray. Resident stated she would really like a milk shake. An interview was conducted on 5/15/24 at 11:30 AM with the Registered Dietitian (RD). The RD revealed she completed a clinical review of the resident's nutritional status and did not routinely observe or interview the residents. The RD stated she was aware Resident #107 was not eating well and was losing weight. The RD stated she was not sure why Resident #107 continued to lose weight. The RD further stated she was not aware that Resident #107 had not received her nutritional supplement. An interview was conducted on 5/16/24 at 3:30 PM with the Nurse Practitioner (NP). The NP indicated she expected that residents would receive nutritional supplements as ordered and weekly weights would be completed as ordered. An interview was conducted on 5/17/24 at 9:50 AM with the Dietary Manager. The Dietary Manager stated she expected that supplements would be on the meal trays as ordered. The Dietary Manager stated she received the order for the nutritional supplement from nursing and then it is put on the meal tray card along with the likes and dislikes and any special items the resident was to receive. The dietary aides were responsible for placing the supplements on the trays. The Dietary Manager stated sometimes she ran out of supplements including Mighty Shakes. The Dietary Manager stated she currently had the Mighty Shake supplement in stock. The Dietary Manager stated it was an oversight that Resident #107 did not receive her Mighty Shakes as ordered and that the extra items were not on her lunch tray on 5/13/24. The Dietary Manager stated she had a lot of new staff, and it was hard to get them to pay attention to the meal tray cards. The Dietary Manager further stated she had a lot of staff turnover, and she was constantly trying to train new staff and trying to make sure they were doing things properly. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 5/17/24 at 1:50 PM with the Administrator. The Administrator stated she expected the residents to receive nutritional supplements as ordered and weekly weights were to be completed as ordered. The physician was not available for interview on 5/17/24. 2. Resident #19 was admitted to the facility on [DATE] with diagnosis which included diabetes and hypertension. Review of Resident #19's electronic health record revealed the following weights were recorded: 11/29/2023- 156.5 pounds (Lbs.) 12/1/2023- 156.5 Lbs. 12/5/2023- 150.7 Lbs. 12/12/2023- 148.4 Lbs. 12/21/2023- 143.7 Lbs. 12/29/2023- 143.0 Lbs. 1/11/2024- 147.3 Lbs. 1/30/2024- 142.2 Lbs. 2/9/2024- 140.0 Lbs. 3/7/2024- 141.6 Lbs. 3/12/2024- 135.0 Lbs. 4/9/2024- 178.0 4/9/2024- 178.0 documented as incorrect documentation. 4/9/2024- 178.0 Lbs. Review of Resident #19's quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated resident had a weight of 178 pounds. The MDS assessment indicated Resident #19 had no weight loss or weight gain of 5 percent in 30 days or 10 percent in 180 days. A review of Resident #19's electronic health record revealed a 4/11/2024 physician order for daily weights for 2 weeks then weekly due to 43-pound weight gain in 1 month. 4/12/2024- 138.4 Lbs. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4/13/2024- 136.2 Lbs. 4/13/2024- 136.2 Lbs. 4/14/2024- 135.6 Lbs. 4/15/2024- 133.2 Lbs. 4/16/2024- 133.9 Lbs. 4/17/2024- 132.6 Lbs. 4/18/2024- 132.2 Lbs. 4/19/2024- 132.4 Lbs. 4/20/2024 No weight recorded. 4/21/2024 No weight recorded. 4/22/2024- 133.3 Lbs. 4/23/2024- 133.4 Lbs. 4/24/2024- 131.5 Lbs. 4/25/2024- 134.7 Lbs. 5/2/2024 No weight recorded. 5/6/2024- 132.6 Lbs. 5/13/2024 No weight recorded. 5/14/2024- 129.7 Lbs. A physician order dated 4/17/2024 indicated regular diet. A 4/19/2024 physician order indicated Resident #19 was to receive Magic Cup supplement one time a day for additional kilocalories and protein. Observation of Resident #19's meal tray ticket on 5/13/2024 at 12:45 PM indicated resident received a regular cardiac consistent carbohydrate diet. The meal ticket also indicated Resident #19 was to receive a Magic Cup. Observation indicated a Magic Cup was not on resident's tray. Observation of Resident #19's meal tray on 5/14/2024 at 12:45 PM revealed no Magic Cup was observed on the meal tray. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Resident #19 on 5/14/2024 at 12:45 PM revealed she could not eat the lunch meal that was served today as it did not look appetizing to her. Resident #19 stated she thought she had lost weight and that she often had crackers and juice for lunch. Observation indicated Resident #19 had a large cooler in her room of foods that her family had brought in. A 5/14/24 Nurse Practitioner (NP) progress note indicated resident was evaluated due to unintentional weight loss over the last 6 months and it appeared to be from the dislike of the taste of the food at the facility. Diet was advanced to regular diet. The progress note did not indicate that Resident #19 was receiving end of life care. An interview was conducted with the Registered Dietitian on 5/15/2024 at 11:10 AM. The RD stated she was following Resident #19 for significant weight loss. The RD stated Resident #19 had a nutritional supplement ordered and she had not heard of any issues with the resident not receiving it. The RD stated she mainly completed a chart review to evaluate the resident's nutritional status and did not observe the meal trays or interview the resident. The RD stated not receiving the nutritional supplement would contribute to continued weight loss. Observation of Resident #19's meal tray on 5/16/2024 at 12:45 PM revealed no Magic Cup was observed on the meal tray. An interview was conducted on 5/16/2024 at 3:30 PM with the Nurse Practitioner (NP). The NP indicated if a resident had an order for a nutritional supplement, she expected the resident to receive the supplement as ordered. The NP further stated resident weights were to be obtained as ordered. An interview was conducted on 5/16/2024 at 4:30 PM with the Director of Nursing (DON). The DON stated she expected the residents to receive nutritional supplements as ordered and resident weights to be obtained as ordered. An interview was conducted on 5/17/2024 at 9:50 AM with the Dietary Manager. The Dietary Manager stated she expected that supplements would be on the meal trays as ordered. The Dietary Manager stated she received a diet slip from nursing with orders for a nutritional supplement and changes in the diet. The Dietary Manager stated she put the nutritional supplement on the meal tray ticket along with the likes and dislikes and any special items the resident received. The dietary aides were responsible for placing the supplements on the meal trays. The Dietary Manager stated sometimes she ran out of nutritional supplements including the Magic Cups but currently she had them in stock. The Dietary Manager stated it was an oversight that Resident #19 did not receive her Magic Cup as ordered this week. The Dietary Manager stated she had a lot of new staff, and it was hard to get them to pay attention to the meal tray cards. The Dietary Manager further stated she had a lot of staff turnover, and she was constantly trying to train new staff and trying to make sure they were doing things properly. An interview was conducted on 5/17/2024 at 1:50 PM with the Administrator. The Administrator stated she expected the residents to receive nutritional supplements as ordered and resident weights to be obtained as ordered.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45711 Based on record review, and resident, staff and Nurse Practitioner interviews, the facility failed to ensure a resident had an appointment scheduled for a physician ordered mammogram (Resident #22) for 1 of 1 resident sampled for medically related social services. Findings included: Resident #22 was admitted to the facility on [DATE]. Resident #22's diagnoses included diabetes and history of left breast keloid (thick scar tisssue resulting from excessive growth of fibrous tissue). Resident #22's quarterly Minimum Data Set (MDS) dated [DATE] indicated the resident was cognitively intact. Review of the facility grievance log revealed a grievance form dated 12/4/23 completed by the resident received by the Director of Nursing/ Assistant Administrator. The grievance was regarding Resident #22's request for a referral for a mammogram. Resident #22 stated she had requested an appointment for a mammogram, and it had not been scheduled. The outcome of the grievance indicated an appointment for a mammogram was to be made for Resident #22. Findings of the grievance indicated Resident #22 had a history of a partial resection of the left breast keloid with request for a mammogram. The grievance indicated follow up was to be made with the provider regarding the request for a mammogram. Grievance resolution was issued to the resident on 12/6/23. Review of a 12/6/23 letter addressed to Resident #22 indicated resident requested an appointment for a mammogram. After an appropriate investigation supervised by the grievance official it was determined that follow up would be made with the provider about the request for a mammogram. Review of a 2/14/24 physician progress note revealed Resident #22 requested a mammography appointment. The progress note indicated the physician would write an order to schedule a mammogram. Review of Resident #22's physician orders revealed a 2/14/24 physician order to schedule a mammography appointment. Review of Resident #22's electronic health record revealed a 2/26/24 Nurse Practitioner progress note which indicated resident again requested a referral for a mammogram. The order was previously written to schedule the mammogram. An interview was conducted on 5/13/24 at 12:04 PM with Resident #22. Resident #22 stated she requested an appointment for a mammogram, and it had not been scheduled. Resident #22 stated she had a history of a cyst in her breast and had not had a mammogram for several years. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A following up interview was conducted on 5/16/24 at 12:26 PM with Resident #22. Resident #22 stated she filed a grievance in December 2023 regarding her request for a mammogram to be scheduled and the appointment had still not been scheduled. Resident #22 further indicated she had breast pain and was concerned about the appointment for the mammogram. Resident #22 stated she was aware that the Nurse Practitioner had written a referral several months ago for the appointment, but it had not been scheduled. An interview was conducted on 5/15/24 at 12:10 PM with the Transportation Specialist. The Transportation Specialist stated she was responsible for scheduling appointments and transportation for the residents and was in the position for the past year. The Transportation Specialist stated she was informed of referrals by the nursing staff, family members and the providers. The Transportation Specialist stated she had not made any appointments lately for Resident #22. She stated she was informed a while back that Resident #22 required an appointment for a mammogram. The Transportation Specialist stated she was still working on trying to get an appointment for the resident for a mammogram. The Transportation Specialist stated she was not sure how Resident #22 needed to be transported and it was difficult to obtain stretcher transportation. An interview was conducted on 5/15/24 at 1:45 PM with the Unit Manager. The Unit Manager stated she was not aware of a referral for Resident #22 to have a mammogram written by the provider in February. The Unit Manager indicated the Transportation Specialist should have been notified of the physician order written in February to schedule a mammogram for Resident #22. An interview was conducted on 5/16/24 at 3:25 PM with the Nurse Practitioner (NP). The NP revealed she would expect to be notified if the facility was not able to schedule an appointment or if there was a delay in obtaining an appointment for a mammogram. The NP indicated a screening mammogram was indicated for Resident #22 and should have been scheduled when the order was written in February. The NP stated the NP that evaluated Resident #22 in February no longer worked at the facility. An interview was conducted on 5/17/24 at 12:20 PM with the Administrator. The Administrator stated Resident #22 had filed a grievance in December regarding the appointment for a mammogram and the resolution of the grievance was that administration would follow up. The Administrator stated she expected the appointment would be made when an order was written, and 5 months was too long to wait to obtain an appointment. The Administrator stated she did not know why there was a breakdown in the process to obtain the appointment for the mammogram following the grievance.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40044 Based on record review, and staff, Pharmacy Consultant, and Nurse Practitioner interviews the facility failed to 1a.) administer the antihypertensive medication Metoprolol prescribed to lower blood pressure, the oral diabetic medication Tradjenta prescribed to lower blood sugar , a phosphate binder Sevelamer (a medication prescribed to lower the amount of phosphorus in the blood when receiving dialysis), and Cymbalta prescribed for neuropathy to a hemodialysis resident after returning from dialysis treatments. This resulted in the resident (Resident #17) not receiving a total of 15 doses of Metoprolol, 15 doses of Tradjenta, 15 doses of Sevelamer, and 8 doses of Cymbalta. 1b.) administer the full course of the oral antifungal Diflucan prescribed for treatment of vaginitis according to the physicians order (Resident #17). This resulted in 2 of the 3 doses of Diflucan not administered. This occurred for 1 of 5 resident reviewed for medication administration (Resident #17). Findings included. 1a.) Resident #17 was admitted to the facility on [DATE] with diagnoses including hypertension, diabetes, end stage renal disease, and neuropathy. A physician's order dated 03/26/24 for Resident #17 revealed Hemodialysis on Tuesday, Thursday, Saturday at 6:00 AM. A physician's order dated 04/02/24 for Resident #17 revealed Metoprolol Succinate extended release 50 milligrams (mgs). Give one tablet by mouth daily for hypertension. Review of Resident #17's Medication Administration Record (MAR) dated April 2024 revealed Metoprolol Succinate extended release 50 milligrams was scheduled for administration daily at 8:00 AM. The MAR had chart code 3 documented on the following dates indicating the medication was not administered due to Resident #17 was out of the facility. 04/02/24 (Tuesday) 8:00 AM: out of the facility. 04/04/24 (Thursday) 8:00 AM: out of the facility. 04/06/24 (Saturday) 8:00 AM: out of the facility. 04/09/24 (Tuesday) 8:00 AM: out of the facility. 04/11/24 (Thursday) 8:00 AM: out of the facility. 04/16/24 (Tuesday) 8:00 AM: out of the facility. 04/18/24 (Thursday) 8:00 AM: out of the facility. 04/23/24 (Tuesday) 8:00 AM: out of the facility. 04/25/24 (Thursday) 8:00 AM: out of the facility. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #17's Medication Administration Record (MAR) dated May 2024 revealed Metoprolol Succinate extended release 50 milligrams was scheduled for administration daily at 8:00 AM. The MAR had chart code 3 documented on the following dates indicating the medication was not administered due to Resident #17 was out of the facility. 05/02/24 (Thursday) 8:00 AM: out of the facility. 05/07/24 (Tuesday) 8:00 AM: out of the facility. 05/09/24 (Thursday) 8:00 AM: out of the facility. 05/11/24 (Saturday) 8:00 AM: out of the facility. 05/14/24 (Tuesday) 8:00 AM: out of the facility. 05/16/24 (Thursday) 8:00 AM: out of the facility. A physician's order dated 04/04/24 for Resident #17 revealed Tradjenta 5 milligrams. Give one tablet once daily for diabetes. Review of Resident #17's Medication Administration Record (MAR) dated April 2024 revealed Tradjenta 5 mgs give one tablet once daily for diabetes was scheduled for administration daily at 8:00 AM. The MAR had chart code 3 documented on the following dates indicating the medication was not administered due to Resident #17 was out of the facility. 04/04/24 (Thursday) 8:00 AM: out of the facility. 04/06/24 (Saturday) 8:00 AM: out of the facility. 04/09/24 (Tuesday) 8:00 AM: out of the facility. 04/11/24 (Thursday) 8:00 AM: out of the facility. 04/16/24 (Tuesday) 8:00 AM: out of the facility. 04/18/24 (Thursday) 8:00 AM: out of the facility. 04/23/24 (Tuesday) 8:00 AM: out of the facility. 04/25/24 (Thursday) 8:00 AM: out of the facility. 04/30/24 (Tuesday) 8:00 AM: out of the facility. Review of Resident #17's Medication Administration Record (MAR) dated May 2024 revealed Tradjenta 5 mgs give one tablet once daily for diabetes was scheduled for administration daily at 8:00 AM. The MAR had chart code 3 documented on the following dates indicating the medication was not administered due to Resident #17 was out of the facility. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	05/02/24 (Thursday) 8:00 AM: out of the facility. 05/07/24 (Tuesday) 8:00 AM: out of the facility. 05/09/24 (Thursday) 8:00 AM: out of the facility. 05/11/24 (Saturday) 8:00 AM: out of the facility. 05/14/24 (Tuesday) 8:00 AM: out of the facility. 05/16/24 (Thursday) 8:00 AM: out of the facility. A physician's order dated 04/02/24 for Resident #17 revealed Sevelamer 800 milligrams. Give 2 tablets three times a day for Hypophosphatemia. Review of Resident #17's Medication Administration Record (MAR) dated April 2024 revealed Sevelamer 800 mgs. Give 2 tablets three times a day for Hypophosphatemia was scheduled for administration three times a day at 8:00 AM, 12:00 PM, and 4:00 PM. The 8:00 AM dose had chart code 3 documented on the following dates indicating the medication was not administered due to Resident #17 was out of the facility. The 12:00 PM and 4:00 PM doses were signed as administered. 04/02/24 (Tuesday) 8:00 AM: out of the facility. 04/04/24 (Thursday) 8:00 AM: out of the facility. 04/06/24 (Saturday) 8:00 AM: out of the facility. 04/09/24 (Tuesday) 8:00 AM: out of the facility. 04/11/24 (Thursday) 8:00 AM: out of the facility. 04/16/24 (Tuesday) 8:00 AM: out of the facility. 04/18/24 (Thursday) 8:00 AM: out of the facility. 04/23/24 (Tuesday) 8:00 AM: out of the facility. 04/25/24 (Thursday) 8:00 AM: out of the facility. Review of Resident #17's Medication Administration Record (MAR) dated May 2024 revealed Sevelamer 800 mgs. Give 2 tablets three times a day for Hypophosphatemia was scheduled for administration three times a day at 8:00 AM, 12:00 PM, and 4:00 PM. The 8:00 AM dose had chart code 3 documented on the following dates indicating the medication was not administered due to Resident #17 was out of the facility. The 12:00 PM and 4:00 PM doses were signed as administered. 05/02/24 (Thursday) 8:00 AM: out of the facility. 05/07/24 (Tuesday) 8:00 AM: out of the facility. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	05/09/24 (Thursday) 8:00 AM: out of the facility. 05/11/24 (Saturday) 8:00 AM: out of the facility. 05/14/24 (Tuesday) 8:00 AM: out of the facility. 05/16/24 (Thursday) 8:00 AM: out of the facility. A physician's order dated 04/25/24 for Resident #17 revealed Cymbalta 60 milligrams (mgs) oral capsules delayed release. Give 30 mgs by mouth in the morning for neuropathy. Review of Resident #17's Medication Administration Record (MAR) dated April 2024 revealed Cymbalta 60 mgs oral capsules delayed release. Give 30 mgs by mouth in the morning for neuropathy was scheduled for administration at 9:00 AM daily. The MAR had chart code 3 documented on the following dates indicating the medication was not administered due to Resident #17 was out of the facility. 04/25/24 (Thursday) 9:00 AM: out of the facility. 04/30/24 (Tuesday) 9:00 AM: out of the facility. Review of Resident #17's Medication Administration Record (MAR) dated May 2024 revealed Cymbalta 60 mgs oral capsules delayed release. Give 30 mgs by mouth in the morning for neuropathy was scheduled for administration at 9:00 AM daily. The MAR had chart code 3 documented on the following dates indicating the medication was not administered due to Resident #17 was out of the facility. 05/02/24 (Thursday) 9:00 AM: out of the facility. 05/07/24 (Tuesday) 9:00 AM: out of the facility. 05/09/24 (Thursday) 9:00 AM: out of the facility. 05/11/24 (Saturday) 9:00 AM: out of the facility. 05/14/24 (Tuesday) 9:00 AM: out of the facility. 05/16/24 (Thursday) 9:00 AM: out of the facility. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #17 had moderately impaired cognition. She had no rejection of care and received hemodialysis. A progress note documented by the Nurse Practitioner dated 05/15/24 revealed in part; Resident #17 was alert and oriented to person, place, and time. She was sitting in her wheelchair at the nurses station in no distress. She was appropriate and not drowsy. Her blood pressure was 116/76 (systolic/diastolic), pulse rate was 88 beats per minute. Her blood sugar was 144 mg/dl (milligrams per deciliter). The cardiovascular exam indicated Resident #17 was at her baseline. Neuropathic pain of stumps (bilateral below knee amputation) to thighs and right hand were minimal. She had no tremors. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/17/24 at 1:00 PM Medication Aide #1 stated on the days Resident #17 was at dialysis she documented code 3 indicating Resident #17 was out of the facility at the time the medications were due. She stated once she documented that the resident was out of the facility the medication would not show up again on the MAR. She stated the medications were not given once Resident #17 returned from dialysis because it did not show on the MAR as needing to be administered. During an interview on 05/17/24 at 2:00 PM the Director of Nursing stated Nurse #4 and Nurse #5 who documented Resident #17 was out of the facility for the dates the medication was not administered in April and May 2024 were not available for interview. She stated Nurse #4 was away on vacation and she made attempts today to contact Nurse #5 and there was no response. She stated the Medical Director was unavailable for interview due to a family emergency. She stated the medication times should have been adjusted to administer to Resident #17 after she returned from dialysis and that was not done. During a phone interview on 05/17/24 at 3:30 PM the Nurse Practitioner stated she routinely evaluated Resident #17 and last examined her on 05/15/24. She indicated she was not aware that Resident #17 was not receiving her morning medications on dialysis days. She stated the Metoprolol was prescribed to Resident #17 to control high blood pressure and her blood pressure reading on 05/15/24 was 116/76 (systolic/diastolic). She indicated her blood pressures have been okay. She stated the Tradjenta was prescribed to Resident #17 for additional protection for diabetes and she also received sliding scale insulin. She stated her blood sugars were stable. She indicated the Cymbalta was prescribed for neuropathy and there had been no reports of increased pain or adverse symptoms. She stated Sevelamer was prescribed to Resident #17 due to being on dialysis and was a phosphate binder. She indicated her phosphorus levels were within normal limits and no abnormal phosphorus levels had been reported from dialysis staff. She stated Resident #17 was alert, oriented, and typically in her wheelchair throughout the day. She stated there had been no reports to her regarding a change of condition and the medication times should have been adjusted to account for dialysis. She indicated Resident #17 had not exhibited any significant outcome from not receiving the Metoprolol, Tradjenta, Cymbalta, or Sevelamer daily. 1b.) A physician's order dated 04/30/24 for Resident #17 revealed Diflucan 150 milligrams. Give one tablet by mouth in the morning every other day for vaginitis. Review of the Medication Administration Record (MAR) dated May 2024 for Resident #17 revealed Diflucan 150 milligrams. Give one tablet by mouth in the morning every other day for vaginitis was scheduled to be administered at 9:00 AM beginning 05/01/24. The medication had chart code 10 documented on the following dates indicating the medication was not available. The MAR read as follows: 05/01/24 9:00 AM 10 medication not available. 05/03/24 9:00 AM 10 medication not available. 05/05/24 9:00 AM the medication was signed as administered. A progress note documented by the Nurse Practitioner dated 05/15/24 revealed in part; Resident #17 was evaluated for urinary tract infection. She was alert and oriented to person, place, and time. She was sitting in her wheelchair at the nurses station in no distress. She was positive for urinary tract infection and would start Gentamycin 80 mgs IM (intramuscular) daily for 7 days. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a phone interview on 05/17/24 at 9:30 AM the Consultant Pharmacist stated the order for Diflucan was received at the Pharmacy on 04/30/24 at 7:00 PM. The Pharmacy dispensed 3 tablets on 05/01/24. She stated Diflucan was also kept in the e-kit (kit located in the facility containing extra doses of medications for backup use) in the facility. Her record showed 6 doses of Diflucan were available on 05/01/24 in the e-kit at the facility. She reported they should have had the full course of the medication available for administration on 05/01/24. She indicated she was not aware of any adverse effects from Resident #17 not receiving the full course of treatment. During an interview on 05/17/24 at 2:00 PM the Director of Nursing stated Nurse #4 and Nurse #5 who documented the medication was not available on 05/01/24 and 05/03/24 were not available for interview. She reported that Nurse #4 was away on vacation, and she had made attempts today to contact Nurse #5 and there was no response. During a phone interview on 05/17/24 at 3:30 PM the Nurse Practitioner stated she was not aware that Resident #17 did not get the 3 doses of Diflucan. She stated it was prescribed for vaginitis and one dose (150 mgs) of Diflucan could be sufficient. She stated she prescribed 3 doses to effectively clear her symptoms. She stated she evaluated Resident #17 on 05/15/24 for symptoms of urinary tract infection (UTI) and prescribed Gentamycin IM (intramuscular) for UTI treatment. She indicated although Resident #17 was positive for urinary tract infection it was not necessarily a direct result from not getting the full course of Diflucan for vaginitis. During an interview on 05/17/24 at 4:00 PM the Director of Nursing (DON) stated 10 on the MAR indicated the medication was not available. She stated the Nurse should have checked the e- kit while waiting for the medication to come from the Pharmacy. She indicated once the medication was available the MAR was not adjusted to account for the missed doses. She stated education had already been started on medication administration last night when she was made aware of the concern with Diflucan. She stated the full course of the Diflucan should have been administered according to the physicians order.

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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. 40044 Based on observations, and staff interviews the facility failed to secure a medication cart that was left unattended and unlocked with the keys in the lock while the cart was in the hallway near resident rooms. This was observed for 1 of 4 medication carts reviewed for medication storage. (400 Hall medication cart) Findings included. During an observation on 05/13/24 at 03:10 PM the medication cart on the 400 hallway was observed unattended and unlocked with the cart keys left in the lock. The nurse was not in site of the cart. A visitor was standing 3 feet away from the medication cart. The nurse was observed coming out of a resident's room from down the hallway approximately 2-3 minutes later. During an interview on 05/13/24 at 3:15 PM Nurse #3 stated she got distracted when she was called away by a resident. She acknowledged she walked away from the medication cart and left the keys in the lock and the cart unlocked. She stated it was done in error. During an interview on 05/17/24 at 11:43 AM the Director of Nursing stated Nurse #3 reported to her after the error. She stated Nurse #3 was called into a resident's room in a hurry and left the cart unlocked. She indicated education would be provided.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45711 Based on observation, record review, resident and staff interview, the facility failed to ensure food was palatable and served at an appetizing temperature for 4 of 8 residents reviewed for food palatability and temperature (Residents #22, #116, and #107) and 5 of 5 Resident Council members in attendance at a Resident Council meeting (Residents #23, #119, #14, #75 and #41). Findings included: 1. Resident #22 was admitted to the facility on [DATE] with diagnosis which included diabetes. Resident #22's quarterly Minimum Data Set (MDS) dated [DATE] indicated the resident was cognitively intact. An interview was conducted with Resident #22 on 5/13/24 at 12:00 PM. Resident #22 revealed the food was cold and not appetizing or cooked well. Resident #22 stated she wished she could make a choice about what she received to eat. Meal observation of Resident #22's lunch tray on 5/13/24 at 12:30 PM revealed resident received 2 chicken tenders, a scoop of potato salad and a scoop of macaroni and cheese. Resident refused the meal and stated the macaroni and cheese was dry and the chicken tenders were hard. Resident #22 requested 2 grilled cheese sandwiches. Resident received 1 grilled cheese sandwich. An interview was conducted on 5/14/24 at 9:12 AM with Resident #22. Resident #22 indicated the food was frequently not hot when it was served, and it was not palatable. Resident #22 stated she had received cold food and food that did not look or taste good for a while. An interview was conducted on 5/17/24 at 9:50 AM with the Dietary Manager. The Dietary Manager stated she was not aware that Resident #22 had any food complaints. The Dietary Manager indicated Resident #22 preferred grilled cheese for lunch and dinner recently and the kitchen provided them per resident's preference. An interview was conducted on 5/17/24 at 12:20 PM with the Administrator. The Administrator stated she was not aware of Resident #22 having any concerns about cold food. 2. Review of Resident #116's 3/19/24 quarterly Minimum Data Set (MDS) assessment revealed resident was cognitively intact. . Interview on 5/13/24 at 1:47 PM with Resident #116 indicated the food often does not look or taste good. Resident #116 stated she frequently drinks a nutritional supplement provided by her family instead of eating due to the meals being cold and not palatable. Resident #116 stated her meals were always cold, not reheated and she often could not eat it because of this. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Meal observation on 5/14/24 at 12:45 PM indicated Resident #116 had her lunch meal tray in front of her which consisted of chicken and dumplings, carrots and mashed potatoes and gravy. Resident #116 indicated she had tried a few bites of her meal but could not eat it. Resident #116 stated the meal did not look appetizing and did not taste good. Resident was observed drinking a nutritional supplement that she received on her meal tray. Resident #116 indicated she was drinking her supplement instead because she could not eat the meal that was served. Resident #116 stated she could ask for an alternate, but it was usually a peanut butter and jelly sandwich, and she could not eat that since she had diabetes. An interview was conducted with the Registered Dietitian (RD) on 5/15/24 at 11:15 AM. The RD stated she was in the position at the facility for 5 months. The RD stated she was not aware of any issues with the food that was served. The RD stated she was not involved with the menu or the diet. The RD stated her main role was to provide a clinical review of the resident's record and this did not involve interview of the resident or observation of the meals. The RD stated Resident #116 had significant weight loss. The RD stated she was not aware Resident #116 was not eating the meals due to concerns with the food temperature and palatability. The RD did not indicate that she would follow up with the Dietary Manager. 3. Resident #107 was admitted on [DATE]. Review of Resident #107's electronic health record revealed a Nurse Practitioner progress note which indicated resident was evaluated on 3/5/24 due to staff concerns that resident's appetite was poor and resident was not eating the meals. The progress note indicated Resident #107 informed the Nurse Practitioner that the food was no good. The progress note further stated the resident had a poor appetite with a down trend in weights. The progress note did not indicate that resident was receiving end of life care. Interview with Resident #107 on 5/13/24 at 11:07 AM revealed the food was not good. Resident #107 stated she kept snacks in her room that her family supplied. Resident #107 stated the food frequently was not hot or palatable. Resident #107 indicated the staff were aware she did not like the food, and they added the extra items that sometimes she received and sometimes she did not. Observation of the lunch meal on 5/13/24 at 12:30 PM revealed Resident #107's meal tray ticket indicated resident was to receive a regular enriched meal program diet with double vegetables, 2 bowls of soup, a peanut butter and jelly sandwich, and a sugar free milk shake supplement. Observation of Resident #107's meal tray revealed resident received a Styrofoam container which contained 2 chicken tenders, a scoop of potato salad, and a scoop of macaroni and cheese. Resident was observed not eating the meal that was provided. Resident had a container with food that her family had provided that she was eating. Interview with Resident #107 indicated the chicken was cold and hard and the macaroni and cheese was cold and dry. Observation of Resident #107's lunch meal tray on 5/14/24 at 12:40 PM revealed resident received two bowls of soup, a peanut butter and jelly sandwich and a foam container which contained chicken and dumplings, carrots and mashed potatoes and gravy. An interview was conducted with Resident #107 on 5/14/24 at 12:40 PM. Resident #107 stated the meal she received was not hot and not palatable. Resident #107 stated the chicken and dumplings looked sloppy and messy with the chicken ground up and it was cold. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with Resident #107 on 5/15/24 at 12:45 PM. Resident #107 stated she ate a peanut butter and jelly sandwich for lunch. Resident #107 stated she did not think she should eat peanut butter and jelly sandwiches every day because she was diabetic, but the meals were not good, and she often just could not eat it. 4. Review of the Resident Council meeting minutes from December 2023 through May 2024 revealed the following food concerns: - 1/3/24 Concern was voiced regarding food thrown on trays and not hot enough. The grievance follow up indicated dietary staff were educated by the manager on food presentation and food temperatures were to be checked prior to leaving the kitchen. The grievance follow up indicated staff were to work on delivering the food quicker to ensure appropriate temperatures on arrival for the residents. - 3/6/24 Concern was voiced regarding vegetables being served mushy. The grievance follow up indicated the Dietary Manager explained that vegetables were sometimes mushy due to cooking a large quantity. - 5/1/24 Concern was voiced that food was not hot when served in Styrofoam trays and meals were repeated frequently. The grievance follow up indicated foam containers were used due to a recent dishwasher fire and they would resume normal meal service once the new dishwasher is installed. During the survey a Resident Council meeting was held on 5/14/24 at 2:30 PM and was attended by the Resident Council President (Resident #23) and a sample of other cognitively intact residents (Resident #119, #14, #75 and #41). The sample of residents in the Resident Council meeting stated the food had been discussed in the Resident Council meetings for months and they continued to receive cold food. The sampled residents stated they received meals that were not palatable and food that did not look or taste good. The residents stated the food was a big concern in the facility. An interview was conducted on 5/16/24 at 4:35 PM with the Director of Nursing (DON). The DON stated the facility needed to work on a system for residents to receive an alternate meal and to ensure the residents received a hot, palatable meal. The DON indicated food service and meal delivery was an area that needed to be investigated more closely. An interview was conducted on 5/17/24 at 9:50 AM with the Dietary Manager. The Dietary Manager stated she was not aware that the residents had any food complaints. The Dietary Manager stated she was not informed of any grievances filed regarding the food. The Dietary Manager stated that she had new staff, and it was hard to get them trained and to pay attention to how the meals were served. The Dietary Manager indicated she had a high turnover of staff and was constantly training staff. The Dietary Manager further stated she had some insulated meal carts, but not enough to deliver all the meals. The Dietary Manager indicated she obtained likes and dislikes from the residents on admission but did not make routine rounds to update these or receive feedback regarding the food. The Dietary Manager stated she was told by the Administrator to improve the food and the food temperatures, but she did not think there was anything she could do. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 5/17/24 at 12:20 PM with the Administrator. The Administrator stated she expected that the food would be palatable and served at an appropriate temperature per resident preferences. The Administrator further stated she expected that staff would offer alternate meals if a resident did not like what was served and would take the meal to the kitchen to be reheated if it was cold.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37673 Based on observations, record review and staff and resident interviews, the facility failed to provide alternative meals for 6 out of 8 residents reviewed for nutrition (Resident # 7, Resident #21, Resident #22, Resident #116, Resident #107, and Resident #19). Findings included: 1a. Resident #7 was admitted to the facility on [DATE]. Review of a quarterly Minimum Data Set assessment dated [DATE] for Resident #7 documented he had intact cognition. In an interview with Resident #21 on 05/16/24 at 12:08 PM he stated when he gets his food it's cold, dried out and hard. He stated he was not aware he could ask for an alternate meal if he did not like what was served to him. 1b. Resident #21 was admitted to the facility on [DATE]. Review of a quarterly MDS assessment dated [DATE] documented Resident #21 had intact cognition. An observation of the lunch meal served to Resident #21 included fried shrimp. In an interview with Resident #21 on 05/13/24 at 2:00 PM she stated she did not eat anything that came out of the ocean, and she was not going to eat the lunch that was served. She stated she had not told dietary about the seafood dislike, but they did know she did not eat eggs or sausage and sometimes she was served both. She reported that she had a dinner that her roommate's family had brought in for her and that was what she planned on eating. She stated she was not offered an alternative. She noted that in the past a staff member came around and reviewed the menu for the week and asked her to choose which meal she preferred. She stated that lasted about 2 weeks and after that no one had been around to offer her an alternate meal choice. She noted she ate food brought in a lot because half the time the food she was served she either didn't like or it was cold when it was served to her. Two examples of documentation for resident meal choices were reviewed. For the week of 04/15/24 documentation showed that residents were asked which meal or alternate was preferred each day beginning on Wednesday, 04/17/24. Residents were not interviewed regarding the menu on 04/15/24 or 04/16/24 of that week. The week of 5/13/24 documentation showed that residents were asked which meal or alternate was preferred each day beginning on Thursday, 05/16/24. Residents were not interviewed regarding the menu on 05/13/24, 05/14/24, or 05/15/24 the week of 05/13/24. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the Administrator on 05/17/24 at 11:23 AM she stated she did expect the residents to have a choice for meal preferences. She explained she did not know why residents were not interviewed this week on 05/13/24, 05/14/24 or 05/15/24 regarding meal choices and were not interviewed on 04/15/14 and 04/16/14 for the week of 04/15/24. She stated the evening receptionist was given a menu for the week. She then was to interview each resident who was able to be interviewed to obtain meal preferences. She stated this process started in April 2024. Prior to that menus were put on each unit and the aides would go around daily and ask each resident what they preferred. She explained that process failed because the aides didn't have time to do that and complete their other duties. In an interview with Receptionist #3 on 05/17/24 at 11:21 AM she stated she had only gone around with the menus and interviewed residents for meal preferences one time and that was this Wednesday. She explained because she wasn't given the menu until Wednesday, she could only interview for preferences beginning with Thursday's menu (05/16/24). In an interview with Receptionist #1 on 05/17/24 at 12:56 PM she stated she had in the past went around and asked residents what meal they wanted for a week at a time. It used to be that a list of residents was made and if any resident wanted something different that day it would be documented and given to the kitchen. She stated that currently it was done weekly. She explained the last time she did this she only asked 9 residents what they preferred to eat each day because it took too long to interview and circle the choices on the menu. She said she was supposed to ask all alert and oriented residents what their preferences were, but she could not get to everyone. She explained after the residents were interviewed the menus would then be given to the kitchen so that meal preferences could be honored each day. She explained the last time she did go around with the weekly menus she could only do Wednesday through Sunday because the menu for the week wasn't given to her until Tuesday evening. In an interview with Receptionist #2 on 5/17/24 at 2:48 PM she stated the process currently in place was to obtain menu preferences for a week at a time. She thought this process had been in place for 2 or 3 months. Prior to that she would go to the halls and ask the nurses which residents were alert and oriented and those were the residents she would interview and review the menu with them. She would circle the resident's choices and return the menus to the kitchen. Usually on Mondays and sometimes Tuesdays no choice were given because the receptionist would not get the menu in time to go around, plus whichever day they went around to inquire about choices would start the following day, not that day. She stated she had been employed since [DATE] and had completed choice menus plenty of times. She noted that recently the main receptionist thought it took too much time away from the receptionist answering the phone and had talked to the Dietary Manager about having someone else go around and interview the residents. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the Dietary Manager on 05/17/24 at 10:31 AM she stated she had worked at the facility for 2 years. She explained the process was for the receptionists to go around and interview residents for meal preferences. When the kitchen received the menus each meal ticket would be adjusted for residents who wanted something other than the main meal. She stated this process had been in place for about a month. She noted the main menus were posted on halls 300, 500, and 700. She explained alternate menu choices are not posted. She noted that any resident who did not get a choice was because the residents were not in their rooms when staff went around to ask. She reported that she was responsible for providing the receptionist with the menu each week. She did not know why for the week of 5/13/24 that residents were not asked what they wanted to eat on 05/13/24, 05/14/24, and 05/15/24 or for the week of 4/15/24 for 04/15/24 and 04/16/24 because the menu was out. She stated she wasn't sure why the process was not working but that it was a work in progress. She stated alternates were available from the everyday menu that included the following choices: cheeseburger, chef salad, cold cut sandwich, grilled cheese, or the chef's daily choice. All entrees except the chef's salad came with chips and the vegetable of the day. 45711 c. Resident #22 was admitted to the facility on [DATE]. Resident #22's quarterly Minimum Data Set (MDS) dated [DATE] indicated the resident was cognitively intact. An interview was conducted with Resident #22 on 5/13/24 at 12:00 PM. Resident #22 stated she wished she could make a choice about what she received to eat. An interview was conducted on 5/14/24 at 9:12 AM with Resident #22. The resident indicated the only thing she was offered as an alternate was a grilled cheese sandwich. A meal observation conducted on 5/16/24 at 12:26 PM revealed Resident #22 was in bed with the head of the bed elevated feeding herself a pasta take out meal. Resident stated she ordered take out as she did not like the lunch and did not want a grilled cheese sandwich again. Resident #22 stated the staff used to take the orders for the meals and offer the meal or an alternate prior to the meal but they had not been doing that for a long time. An interview was conducted on 5/17/24 at 9:50 AM with the Dietary Manager. The Dietary Manager stated she was not aware of Resident #22 having any food complaints. The Dietary Manager stated she had items available for alternate meals. The Dietary Manager indicated the facility was asking the residents about alternate meals, but it had not been done recently. An interview was conducted on 5/17/24 at 12:20 PM with the Administrator. The Administrator further stated she expected food preferences to be honored, residents to be served meals according to their preferences and alternate meals to be provided. d. Resident #116 was admitted to the facility on [DATE] with diagnosis which included in part chronic obstructive pulmonary disease and diabetes. Review of Resident #116's electronic health record revealed a physician order dated 1/22/24 for a consistent carbohydrate diet. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345119	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northchase Nursing and Rehabilitation Center	3015 Enterprise Drive Wilmington, NC 28405

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #116's 3/19/24 quarterly Minimum Data Set (MDS) assessment revealed resident was cognitively intact. Interview on 5/13/24 at 1:47 PM with Resident #116 indicated the food often did not look or taste good and she was not aware of an alternate meal other than a peanut butter and jelly sandwich. Resident #116 stated she frequently drank a nutritional supplement provided by her family instead of eating. Meal observation on 5/14/24 at 12:45 PM revealed Resident #116 was sitting on the side of her bed with her lunch tray in front of her. Resident #116 had not eaten any of the lunch. Resident was observed drinking her nutritional supplement. Interview on 5/14/24 at 12:45 PM with Resident #116 revealed she was drinking a nutritional supplement instead of eating the meal. Resident #116 stated she did not like the meal and was not aware of a list of alternate meals. Resident #116 stated she knew that she could get a peanut butter and jelly sandwich, but she could not eat that since she was a diabetic. e. Resident #107 was admitted on [DATE] with diagnosis which included stroke and diabetes. Interview with Resident #107 on 5/13/24 at 11:07 AM revealed the food was not good and she mostly ate snacks supplied by her family. Resident #107 was not aware of alternate options at meals. Meal observation on 5/13/24 at 12:30 PM revealed Resident #107's was in bed with the head of the bed elevated with her meal tray in front of her. Resident #107 had not eaten from the meal tray but instead was eating from a container of food that her family had provided. An interview was conducted with Resident #107 on 5/14/24 at 12:40 PM. Resident #107 stated the meal she received was not hot and not palatable and she was not offered an alternate. An interview was conducted with Resident #107 on 5/15/24 at 12:45 PM. Resident #107 stated she ate a peanut butter and jelly sandwich for lunch. Resident #107 stated she was told you get what you get for your meals. Resident #107 stated she did not like to eat peanut butter and jelly sandwiches every day because she was diabetic. Resident #107 stated the food was not good, she often just could not eat it and was not offered an alternate meal. f. Resident #19 was admitted to the facility on [DATE] with diagnosis which included diabetes and hypertension. Review of Resident #19's 4/11/24 quarterly Minimum Data Set (MDS) assessment indicated resident was cognitively intact. Interview with Resident #19 on 5/14/24 at 12:45 PM revealed she could not eat the lunch meal that was served as it was not appetizing. Resident #19 stated sometimes staff stated they did not have an alternate meal available. An interview was conducted on 5/17/24 at 9:35 AM with Nurse #1. Nurse #1 stated the facility used to give copies of the menu and asked the residents if they wanted the meal or an alternate, but it had not been done for a while. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 5/17/24 at 1:50 PM with the Administrator. The Administrator stated she expected the residents to receive alternate meals. The Administrator stated she did not know what the breakdown was with the alternate meals.

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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. 40044 Based on observations, record review, and staff, resident, and the Nurse Practitioner interviews the facility failed to implement the Enhanced Barrier Precautions (EBP) policy regarding donning Personal Protective Equipment (PPE) to include donning gloves and gown during high contact resident care activities. Two Nurse Aides were observed providing care to a resident with an indwelling central venous catheter used for dialysis and who received wound care to the right lower extremity and were not wearing a gown during care. This occurred for 1 of 5 resident (Resident #82) observed for Infection Control. Findings included. The facility's Enhanced Barrier Precautions policy updated on 04/01/24 read: Enhanced Barrier Precautions were used in conjunction with Standard Precautions to reduce the risk of multidrug resistant organism (MDRO) transmission during high contact resident care activities. This included the use of both gloves and gown. Enhanced Barrier Precautions are to be in place for the duration of the residents stay or until resolution of a wound or discontinuation of an indwelling medical device. During an observation on 05/14/24 at 9:45 AM a sign was posted by Resident #82's room door that read in part: Enhanced Barrier Precautions. Providers and staff must wear gloves and a gown for the following high-contact resident care activities: dressing, bathing, showering, transferring, changing linens, providing hygiene, changing briefs, device care or use of a central line, urinary catheters, feeding tubes, and wound care. During an observation on 05/14/24 at 9:45 AM Nurse Aide #3 was observed in Resident #82's room changing the bed linens. Resident #82 was sitting at the bedside in her wheelchair. Nurse Aide #3 had on gloves when changing the bed linens but no gown. A cart with PPE (personal protective equipment) supplies was in the residents room. Nurse Aide #3 stated she had a gown on when she transferred Resident #82 to the wheelchair then took it off before changing the bed linens. She stated she knew Resident #3 was on Enhanced Barrier Precautions and acknowledged that she should wear a gown and gloves when providing direct care including changing bed linens. She indicated she had received training on Enhanced Barrier Precautions. She stated it was done in error. During an interview on 05/14/24 at 9:45 AM Resident #82 was alert and oriented to person, place, and time. She stated she was on precautions because of her dialysis port, and she had a wound on her leg. She stated she had also been on Contact Precautions for a while due to C. diff. (clostridium difficile - a bacteria that causes infection of the colon). During an interview on 05/14/24 at 10:00 AM the Nurse Practitioner stated Resident #82 was no longer on Contact Precautions for C. difficile as of 05/13/24 and was now on Enhanced Barrier Precautions due to having a dialysis access device and receiving wound care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 05/15/24 at 2:10 PM Nurse Aide #4 was observed in Resident #82's room providing incontinence care. She was observed wearing gloves but no gown. She stated she had the gown on at first then discarded it then started with incontinence care without replacing her gown. She stated she had received training on Enhanced Barrier Precautions. She stated it was a mistake and she should have put a gown on before providing incontinence care. During an interview on 05/17/24 at 09:30 AM the Infection Control Nurse indicated Resident #82 was on Enhanced Barrier Precautions due to having a dialysis access device and wound care. She stated Resident #82 came off of Contact Precautions for C. difficile on 05/13/24 and was now on Enhanced Barrier Precautions. She indicated the nurse aides had been trained on Enhanced Barrier Precautions and should have worn a gown along with gloves when providing direct care. During an interview on 05/17/24 at 5:00 PM the Director of Nursing (DON) stated staff should wear the appropriate PPE when providing direct care to residents on Enhanced Barrier Precautions. She stated education would be provided.