STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345132	A. Building B. Wing	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenhaven Health and Rehabilitation Center	801 Greenhaven Drive Greensboro, NC 27406

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32394 Based on observations, resident and staff interviews, and record reviews, the facility failed to allow residents assessed to be safe to smoke the ability to smoke independently at any time of his/her choice. This occurred for 3 of 3 residents (Resident #47, #8, and #69) who expressed a desire to smoke at times other than the supervised smoking times designated by the facility. This practice had the potential to affect other safe smokers in the facility. The findings included: A review of the facility's Smoking Policy (Revised on 10/15/22) was conducted. A section of the policy entitled Determination of Smoking Residents' Supervision Needs included the following Procedures, in part: #3 (of 6). After completion of each assessment, the interdisciplinary care plan (ICP) team will review and determine the smoking status (supervised/unsupervised) of the resident. a) When the Smoking Evaluation identifies a resident with any potential hazard risk, including but not limited to a cognitive deficit, the resident will be allowed to smoke only during this facility's designated smoking times with direct staff supervision. b) When the Smoking Evaluation identifies a resident without any potential hazard risk and who is safe to smoke independently, the resident will be allowed to smoke unsupervised, at any time of his/her choice. An observation was conducted on 3/12/24 at 3:13 PM of a sign placed on the door leading to the facility's designated smoking area. The sign read: Smoking Schedule 1st 11:00 AM - 11:30 AM 2nd 2:00 PM - 2:30 PM 3rd 5:00 PM - 5:30 PM (continued on next page)

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

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. Resident #47 was admitted to the facility on [DATE] with cumulative diagnoses which included diabetes and history of a stroke. The resident's most recent Minimum Data Set (MDS) was an annual assessment dated [DATE]. The MDS revealed Resident #45 had intact cognition. A review of Resident #47's electronic medical record (EMR) included a Smoking Evaluation dated 3/2/24. The Outcome section of the Smoking Evaluation reported the following: 1. Outcome: Resident is a safe smoker and may smoke independently at this time. 2. Resident Education: Education on Smoking Policy provided. In agreement to follow. 3. Care Plan reviewed and revised as necessary (Dated 3/2/24). An interview was conducted on 3/12/24 at 3:40 PM with Resident #47. During the interview, the resident confirmed she was a smoker. When asked, Resident #47 reported that although she was a safe smoker, she was only allowed to smoke during the scheduled smoking times of 11:00 AM, 2:00 PM and 5:00 PM. She stated that they (the smokers) didn't understand why they were only allowed to go out at these times if they were safe smokers. b. Resident #8 was admitted to the facility on [DATE] with cumulative diagnoses which included diabetes and cerebrovascular disease (a disorder where the blood flow to the brain is affected). The resident's most recent Minimum Data Set (MDS) was a quarterly assessment dated [DATE]. The MDS revealed Resident #8 had intact cognition. A review of Resident #8's electronic medical record (EMR) included a Smoking Evaluation dated 3/2/24. The Outcome section of the Smoking Evaluation reported the following: 1. Outcome: Resident is a safe smoker and may smoke independently at this time. 2. Resident Education a. Education on Smoking Policy provided. In agreement to follow. 3. Care Plan reviewed and revised as necessary (Dated 3/2/24). An interview was conducted with Resident #8 on 3/12/24 at 4:20 PM. During the interview, Resident #8 confirmed she was a smoker. The resident reported she was only allowed to smoke during the supervised smoking times designated by the facility (11:00 AM, 2:00 PM, and 5:00 PM). When asked, the resident reported she was not happy she was limited to smoking during the facility's designated smoking times. c. Resident #69 was admitted to the facility on [DATE] with cumulative diagnoses which included non-traumatic spinal cord dysfunction. The resident's most recent Minimum Data Set (MDS) was a quarterly assessment dated [DATE]. The MDS revealed Resident #69 had moderately impaired cognition. (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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #69's electronic medical record (EMR) included a Smoking Evaluation dated 3/2/24. The Outcome section of the Smoking Evaluation reported the following: 1. Outcome: Resident is a safe smoker and may smoke independently at this time. 2. Resident Education: Education on Smoking Policy provided. In agreement to follow. 3. Care Plan reviewed and revised as necessary (Dated 3/2/24). An interview was conducted on 3/12/24 at 4:25 PM with Resident #69. During the interview, the resident confirmed she was a smoker and was only allowed to smoke at 11:00 AM, 2:00 PM and 5:00 PM. When asked what her thoughts were about the designated smoking times, the resident emphatically stated she wanted More! An observation was conducted on 3/13/24 at 11:10 AM as an Activities Department Aide unlocked the coded door leading to the facility's designated smoking area. Residents wishing to smoke were observed to follow the Aide outdoors to the enclosed patio. An interview was conducted on 3/13/24 at 11:15 AM with the Activities Director as she approached the smoking area. When asked, the Activities Director reported the Activities Department assumed the primary responsibility to supervise all the smokers during the scheduled smoking times. An interview was conducted on 3/13/24 at 3:30 PM with the facility's Interim Administrator in the presence of the corporate Regional [NAME] President. During the interview, the concern related to the facility's mandated supervision and restriction of smoking times for residents assessed as safe smokers was discussed. The Interim Administrator reported the supervised smoking schedule was already in place when he came to the facility in mid-January. He confirmed the designated, supervised smoking times currently applied to all smokers. The Interim Administrator stated, It's an issue that needs to be addressed.

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F 0576 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure residents have reasonable access to and privacy in their use of communication methods. 49007 Based on resident and staff interviews, the facility failed to provide mail delivery to the residents on Saturdays for 9 of 9 (Resident #1, #11, #16, #283, #42, #14, #45, #47 and #50) residents in resident council. Findings included: An interview with members of the resident council on 3/12/24 at 1:30 pm revealed that the facility did not deliver any mail on Saturdays. The members present for the meeting were Resident #1, Resident #11, Resident #16, Resident #283, Resident #42, Resident #14, Resident #45, Resident #47 and Resident #50. All residents that were present indicated they did not receive mail on Saturdays. The residents reported that mail was only delivered during the week by the Activities Director (AD) and/or her Aide and they had to wait until Monday to receive mail. An interview was conducted on 3/12/24 at 2:57 pm with the Activities Department Aide. She revealed the activities department delivered mail Monday through Friday and on Monday they have mail in their mailbox from the weekends. She was aware that mail should be delivered on Saturdays, but indicated it probably was not delivered on Saturdays. An interview was conducted on 3/12/24 at 3:00 pm with the Activities Director (AD) who revealed she or her Aide delivered mail Monday through Friday. The weekend Receptionist was supposed to deliver mail on the weekends, but they had a new Receptionist, and she may not been aware that she should have delivered mail. The Receptionist started less than a couple of weeks ago. Interview further revealed that the AD didn't know there was a problem and she would talk to the new Receptionist to put a plan in place right now. An interview was conducted on 3/13/24 at 5:38 pm with the evening and weekend Receptionist and revealed that mail was delivered to the front desk on the weekends and she either placed mail in the AD's box or the Accounts Receivable Director's (ADR) box. Interview further revealed she started working at the facility less than a couple of weeks ago and her role was to make sure the mail was placed in the AD's box or the ARD's box, not to deliver to the residents. During an interview on 3/14/24 at 1:56 pm, the Administrator indicated they would have staff deliver the mail to residents on Saturdays.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46725 Based on record review, resident, and staff interviews the facility failed to investigate and resolve grievances for Residents #46 and #42 and maintain evidence demonstrating the result of the grievances for Residents #282, #29, #68. This was for 5 of 5 residents reviewed for grievances. The findings included: 1a. Resident #46 was admitted on [DATE]. A review of Resident #46's grievance dated 1/8/24 was conducted and revealed no documented investigation or follow up noted on the grievance form. An interview was conducted with Resident #46 on 12/1/2023 at 1:45 PM and she revealed she had shared a grievance regarding poor call light response times and never received a response. 1b. Resident #42 was admitted on [DATE]. A review of Resident #42's grievances dated 1/8/24 and 1/24/24 was conducted and revealed no documented investigation or follow up noted on the grievance form. The 1/8/24 grievance expressed by Resident #42 was related to the failure of the nursing staff to provide Activities of Daily Living (ADL) care in a timely manner. The grievance shared on 1/24/24 was regarding the resident's medications, incontinence care, and staff failing to be polite in their interactions with her. An interview was conducted with Resident #42 on 3/14/24 at 3:55 PM. During the interview, the resident was asked if she recalled whether the facility responded to the concerns/grievances she had shared on 1/8/24 and 1/24/24. Resident #42 was unable to recall what the concerns were at that time and therefore, she could not address whether she received a response from the facility or follow-up information on the resolution of these concerns. 2. A review of the facility grievance log was conducted from August 2023 to March 2024. The review revealed logged grievances for Resident 281 dated 10/9/23, a grievance for Resident # 282 dated 11/5/23 and a grievance for Resident #68 dated 9/29/23. No copies of these three grievances were provided by the facility. An interview was conducted on 3/14/24 at 9:57 AM with the Administrator. He revealed that he was not able to provide completed grievances forms for residents #46 and #42 but felt that the grievances had been investigated. He also revealed Residents #282, #68, and #281 had logged grievances but the facility did not maintain a copy of these grievances and was not sure why this occurred. A follow up interview was conducted on 3/14/24 at 8:02 AM and he revealed that he was not able to locate any of the missing information and that the facility should have a documented record of grievance resolution, complainant follow up and the records should have been maintained for three years.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 49007 Based on record review and staff interviews, the facility failed to complete and submit an initial report within 2 hours to the state regulatory agency for an allegation of family provided sitter to resident abuse for 1 of 3 residents reviewed in facility reported incidents (Resident #68). Findings included: A review of the initial report on 1/13/24 at 11:30 pm revealed the facility was made aware Resident #68 alleged his family provided sitter hit him in the stomach. No injuries were reported. The initial report was faxed to the state regulatory agency on 1/14/24 at 4:52 pm. An interview was conducted with the Administrator on 3/14/24 at 1:48 pm which revealed he was made aware of the allegation of abuse on 1/13/24 around 11:30 pm and immediately started their investigation. Interview further revealed Administrator did not have access to a fax machine. The Administrator indicated all steps were taken within 2 hours except faxing in the initial report to the state regulatory agency.

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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** 32394 Based on staff interviews and record reviews, the facility failed to review and revise a resident's care plan when indicated for 4 of 29 sampled residents (Resident #47, Resident #8, Resident #69, and Resident #46). The care plan for Residents #47, #8 and #69 were not revised to accurately reflect the results of their Smoking Evaluation. Resident #46's plan of care was not updated when there was a change in her Advance Directive. The findings included: 1-a. Resident #47 was admitted to the facility on [DATE] with cumulative diagnoses which included diabetes and history of a stroke. The resident's most recent Minimum Data Set (MDS) was an annual assessment dated [DATE]. The MDS revealed Resident #47 had intact cognition. A Smoking Evaluation was completed on 3/2/24. The Outcome section of the Smoking Evaluation reported the following: 1. Outcome: Resident is a safe smoker and may smoke independently at this time. 2. Resident Education: Education on Smoking Policy provided. In agreement to follow. 3. Care Plan reviewed and revised as necessary The resident's current Care Plan included the following area of focus, Resident is a supervised smoker / Problematic manner in which resident acts characterized by inappropriate smoking of tobacco related to: Cognitive impairment, Physical limitations (Revised on 4/21/23). Goal: Resident will smoke safely in designated areas with supervision thru next review. Interventions included, in part: Evaluate resident's ability to smoke safely on a consistent and regular basis. 1-b. Resident #8 was admitted to the facility on [DATE] with cumulative diagnoses which included diabetes and cerebrovascular disease (a disorder where the blood flow to the brain is affected). Review of the resident's EMR indicated her most recent Minimum Data Set (MDS) was a quarterly assessment dated [DATE]. The MDS revealed Resident #8 had intact cognition. A review of Resident #8's EMR included her most recent Smoking Evaluation dated 3/2/24. The Outcome section of the Smoking Evaluation reported the following: 1. Outcome: Resident is a safe smoker and may smoke independently at this time. 2. Resident Education a. Education on Smoking Policy provided. In agreement to follow. 3. Care Plan reviewed and revised as necessary (Dated 3/2/24). (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident's current Care Plan was reviewed and included the following area of focus, Resident has been evaluated to be an unsafe smoker due to smoking in unauthorized areas. The care plan was last revised on 9/8/23. Goal: Resident will smoke safely in designated areas with supervision thru next review. Interventions included, in part: Assist resident to designated smoking areas during established facility smoking times and Do not leave resident unattended while smoking. 1-c. Resident #69 was admitted to the facility on [DATE] with cumulative diagnoses which included non-traumatic spinal cord dysfunction. Further review of the resident's EMR indicated her most recent Minimum Data Set (MDS) was a quarterly assessment dated [DATE]. The MDS revealed Resident #69 had moderately impaired cognition. A review of Resident #69's electronic medical record (EMR) included her most recent Smoking Evaluation dated 3/2/24. The Outcome section of the Smoking Evaluation reported the following: 1. Outcome: Resident is a safe smoker and may smoke independently at this time. 2. Resident Education: Education on Smoking Policy provided. In agreement to follow. 3. Care Plan reviewed and revised as necessary (Dated 3/2/24). The resident's current Care Plan was reviewed and included the following area of focus, Resident is a supervised smoker. Goal: Resident's preference to use tobacco/tobacco substitute products of her choices will be honored thru next review. An interview was conducted with the facility's Director of Nursing (DON) in the presence of the Regional Nurse Consultant. Upon inquiry as to who was responsible to ensure a resident's care plan accurately reflected the results of a resident's Smoking Evaluation, the DON stated the MDS nurse assumed that responsibility. She stated both a resident's Smoking Evaluation and care plan should include the same information. An interview was conducted on 3/14/24 at 11:45 AM with the MDS nurse. During the interview, the MDS nurse reviewed the most recent Smoking Evaluations and care plans for Resident #47, Resident #8, and Resident #69. The nurse confirmed the care plans were not in agreement with each resident's most recent Smoking Evaluation and determination of being a safe, independent smoker. The MDS nurse reported she would need to modify each residents' plan of care to accurately reflect the conclusion of the residents' Smoking Evaluations. An interview was conducted on 3/14/24 at 3:30 PM with the facility's Interim Administrator. Concern regarding the residents' care plans not containing the same information as indicated by their Smoking Evaluations was discussed. The Interim Administrator stated he had been made aware of the issue and that it would need to be addressed. 46725 2. Resident #46 was admitted on [DATE]. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The most recent Minimum Data Set (MDS) was a significant change in status assessment dated [DATE], which revealed Resident #46 had intact cognition. A review of Resident #46 electronic medical record (EMR) revealed a physician's order dated 1/4/24 to change the full code status to Do Not Resuscitate (DNR). A review of Resident #46's paper chart revealed a physician signed DNR form effective 1/4/24 with no expiration date. A review of Resident #46's care plan noted as revised on 1/25/24 revealed a care plan for full code status. An interview was conducted with MDS Nurse #2 on 03/13/24 at 10:20 AM. She confirmed that she revised the care plan on 1/25/24 to continue the full code directive and did not realize that there was a new order for DNR on 1/4/24. She further revealed the care plan should have been updated to reflect the change in code status to a Do Not Resuscitate but it was missed. An interview was conducted with the Administrator on 03/14/24 at 08:01 AM. He revealed that when a change in code status occurs the residents care plan should be updated to reflect the correct code status.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20906 Based on observations, staff interviews and record review, the facility failed to apply splints for 1 of 1 resident (Resident #33) reviewed for contractures. The findings included: Resident #33 was admitted on [DATE] with diagnoses of hypertension, diabetes, cerebral vascular accident, and left-hand contracture/hemiparesis. Review of admission Minimum Data Set(MDS), dated [DATE] , indicated Resident #33 was severely cognitively impaired and required total assistance with activities of daily living. The MDS coded Resident #33 with left hand contracture. Review of the occupational discharge summary dated 2/1/24, documented Resident #33 met the goal on 2/12/24. Resident #33 exhibited left upper extremity pain with passive range of motion and application of resting hand splint. Resident #33 tolerated up to 4 hours wearing once splint was applied. Review of the functional maintenance record restorative phase three for Resident #33 completed by occupational therapy on 2/9/24, range of motion task was to provide passive range of motion to left upper extremities daily with activities of daily living. The approach was to apply the resting hand splint for two hours daily. Review of the physician order dated 2/26/24, revealed an occupational therapy evaluation and treatment for contracture management, documented place left hand orthotic once daily. There was no documentation of when to remove splint. Review of the Medication Administration Records (MAR) for February 2024 and March 2024 for Resident #33 revealed documentation of the left-hand splint application was being done at 7:30 AM. An observation was conducted on 3/11/23 at 10:10 AM, Resident #33 was in bed and her left hand was contracted with no splint. There was no splint available in the room. An observation was conducted 03/11/24 11:34 AM, the left hand continued to be without a splint. There was no splint available in the room. An observation was conducted on 3/12/24 at 7:45 AM, the left hand had no splint in place. There was no splint available in the room. An observation was conducted on 3/12/24 at 8:20 AM, resident in bed with a splint in place. An observation was conducted on 3/12/24 at 10:00 AM, resident remain in bed without splint in place. There was no splint available in the room. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation was conducted 3/12/24 at 12:26 PM, with the Director of Nursing, Resident #33 was in bed with no splint in place on her left hand. The Director of Nursing confirmed Resident #33's left hand was contracted and there was no splint in place. She further stated Resident #33's splint was not on the list of residents who had assistive devices provided by the rehabilitation therapy department. She stated she would follow-up with therapy regarding the use of a splint for Resident #33. The Director of Nursing stated she was unaware of the location of the splint. An interview was conducted on 3/12/24 at 12:36 PM, Nurse Aide #4 stated she was not sure Resident #33 wore a hand splint and could not recall when the resident had a left-hand splint . She did not apply the splint application because she did not know she wore one. An interview was conducted on 3/12/24 at 3:00 PM, in conjunction with a record review with Nurse#3, stating she was unaware the resident had an order for a splint. Nurse#3 reviewed the physician orders and confirmed there was order for a left hand orthotic to be worn every day. She stated orders for splint application would have been on the MAR. Review of the MAR revealed documentation the splint was applied but she could not recall when she had observed left-hand splint on the resident. The Nurse #3 searched for the splint in the room and the splint could not be located. An interview was conducted on 3/12/24 at 3:44 PM, in conjunction with an observation with Nurse Aide #5 stated she reviewed the resident care card and there was no information about the resident wearing any type of splint. The care card only stated the resident always wore a protective boot on left foot. Nurse Aide #5 confirmed there was no splint in place on the left hand. Nurse Aide #5 stated was she unaware the resident should be wearing a splint. An interview was conducted on 3/12/24 at 4:00 PM, the Nurse#4 stated she was unaware the resident had an order for a splint. She indicated she did not know where the splint was located. She further stated when residents wore splints, the information would be on the physician order and flagged on the medication administration record as a reminder to ensure the splints were applied. A follow-up interview was conducted 3/13/24 at 1:49 PM, in conjunction with a record review with the Director of Nursing reviewed the occupation therapy discharge summary dated 2/12/24, revealed the resident was to wear the splint for 4 hours a day and staff were trained on the application process. She confirmed the physician order dated 2/26/24 for the left-hand orthotic was to be worn every day. The Director of Nursing further stated the physician order would include frequency of donning/doffing and the care plan would be updated to reflect the addition of the splint. She further stated nursing would also document on the MAR when the splint was applied and removed. The Director of Nursing stated she was unaware of the location of the splint at this time and would place the splint order on hold until the resident could be re-evaluated, and all staff trained on the application of the splint. She stated she would follow-up with therapy regarding the use of a splint for Resident #33. The Director of Nursing stated she was unaware of the location of the splint An interview was conducted on 3/12/24 at 2:00PM, in conjunction with a record review with the Certified Occupational Therapist Assistant stated therapy was doing trial palm splints/hand rolls on the resident from 1/24/24-2/12/24, she stated the discharge summary documented the resident tolerated the splint application up to 4 hours once splint was applied. She reviewed the order dated 2/26/24 and confirmed the transcription of the order did not include what was in the discharge summary and staff knowledge or application of splint was not available. She also confirmed the location of the splint was also not available. (continued on next page)

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Greenhaven Health and Rehabilitation Center	801 Greenhaven Drive Greensboro, NC 27406

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation was conducted on 3/13/24 at 7:30 AM, Resident #33 was lying in bed without splint. A follow-up observation was conducted on 3/13/24 at 8:43 AM, in conjunction with record review, with the Director of Nursing, revealed Resident #33 did not have a splint on and there was no splint available for the resident. The Director of Nursing acknowledged that staff had been documenting on the medication administration record(MAR) for February 2024 and March 2024, the splint was being applied at 7:30 AM, 3/11/24-3/13/24 during the week of survey, however there was no splint in place or available.

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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. 33778 Based on observations and staff interviews, the facility failed to remove the expired medications from the refrigerator and expired supply kits from the medication storage room. Findings included: On 3/11/24 at 12:45 PM, observation of the medication storage room with Nurse #6 revealed: a. in the refrigerator, there were two opened and not dated multi-dose vials of Influenza Vaccine, 5 milliliters (ml); one multi-dose vials of Influenza Vaccine, 5 ml, opened on 11/8/23. The manufacturer's instruction was to discard after 30 days, which would be on 12/1/23. There was one expired multidose vial of Levemir insulin, 100 units in 1 milliliter, 10 milliliters, opened on 1/6/24 and marked to discard on 2/13/24. b. inside the cabinets, there were 18 expired sealed plastic bags of Secondary Administration Sets (3 of them expired on 7/20/23, 5 - on 8/1/23, 6 - on 8/8/23 and 4 - on 8/20/23); 1 sealed plastic bag of Dressing Change Tray, expired on 11/23/23; 1 plastic bag of Foley Catheter Insertion Tray, expired on 10/31/22 and 4 Pivodon-Iodine Swab sticks, expired in November 2023. On 3/11/24 at 1:15 PM, during an interview, Nurse #6 indicated that the nurses who worked on the medication carts, were responsible for discarding expired medications from the medication storage room. She mentioned that per training, every nurse should check the date of opening on multi-dose medications. The nurse stated that she had not checked the expiration date of medications in the medication storage room at the beginning of her shift. On 3/11/24 at 1:25 PM, during an interview, the Director of Nursing (DON) indicated that all the nurses were responsible to check all the medications in medication storage rooms for expiration date and remove expired medications and supplies every shift. She expected that no expired items be left in the medication storage room. On 3/11/24 at 1:30 PM, during an interview, the Administrator expected no expired items to be left in the medication storage rooms.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 46725 Based on record review and staff interview, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions the committee put into place following the recertification and complaint survey dated 4/12/21 and the recertification and complaint survey dated 1/13/23. This was for one deficiency in the area of Grievances (585) which was originally cited during the recertification and complaint investigation survey conducted on 4/12/21 and recited during the current recertification and complaint investigation conducted on 3/14/24. In addition, Care Plan timing/revision (657) and Medication Storage (761) here were originally cited during the recertification and complaint investigation survey conducted on 1/13/23 and recited during the current recertification and complaint investigation conducted on 3/14/24. The repeated citations during the three surveys of record showed a pattern of the facility's inability to sustain an effective QAA program. Findings included: This tag is cross referenced to: F 585: Based on record review, resident, and staff interviews the facility failed to investigate and resolve grievances for Residents #46 and #42 and maintain evidence demonstrating the result of the grievances for Residents #282, #29, #68. This was for 5 of 5 residents reviewed for grievances. During the recertification and complaint survey dated 4/12/21 the facility failed to initiate a written grievance summary for grievances verbally reported for one of one resident reviewed for grievances. F 657: Based on staff interviews and record reviews, the facility failed to review and revise a resident's care plan when indicated for 4 of 29 sampled residents (Resident #47, Resident #8, Resident #69, and Resident #46). The care plan for Residents #47, #8 and #69 were not revised to accurately reflect the results of their Smoking Evaluation. Resident #46's plan of care was not updated when there was a change in her Advance Directive. During the recertification and complaint survey dated 1/13/23 the facility failed to review and update a care plan and ensure the care plan was signed for 1 of 5 residents reviewed for weight loss. F 761: Based on observations and staff interviews, the facility failed to remove the expired medications from the refrigerator and expired supply kits from the medication storage room. During the recertification and complaint survey dated 1/13/23 the facility failed to label inhalers and multidose vials with the date open and date to expire, dispose of expired medications, keep a medication refrigerated per pharmacy instructions, and label inhalers with the minimum required labeling (including a resident's name and instructions for administration) in 1 of 2 medication carts (Hall 300) and 1 of 1 medication rooms observed. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the Administrator was conducted on 03/14/24 at 5:10 pm. He indicated his expectation was for the team to work together to maintain an effective Quality Assurance Performance Improvement Committee to ensure the facility does not repeat a previous deficient practice.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 41579 Based on facility policy review, record review and staff interview the facility failed to monitor antibiotic usage in the facility for 6 of 13 months reviewed (August 2023, September 2023, October 2023, November 2023, December 2023, January 2024). Findings included: Review of the facility's policy titled Antibiotic Stewardship, revised on 03/04/24 revealed the following: As a component of this facility's IPCP (infection prevention control program), the antibiotic stewardship program supports the appropriate and safe use of antibiotics in the treatment of residents' infections with a focus on the development and reduction of antibiotic-resistant organisms. On 03/14/24 at 3:00 pm an interview was conducted with the Assistant Director of Nursing (ADON), and she indicated she was unable to locate 2023 antibiotic stewardship information initially then presented with January 2023 through July 2023 antibiotic stewardship information. A review of February 2023 through January 2024 antibiotic stewardship revealed no information for antibiotic monitoring for the months of August 2023 through December 2023 and January 2024. During an interview on 3/14/24 at 4:15 pm with the Regional Nurse Consultant she indicated the previous ADON was responsible for the antibiotic stewardship, and she was here until December 2023. She indicated they were trying to find the rest of the antibiotic information. Attempted to contact the previous ADON and was unsuccessful. On 03/14/24 at 4:21 pm an interview was conducted with the Director of Nursing (DON), and she indicated her expectation was to monitor the antibiotics and infections on day one of the start of antibiotic. She indicated when an antibiotic started, they would ensure it was needed, track and trend the infections and review specifics of particular issues of infection monitoring monthly.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41579 Based on record reviews and staff interviews, the facility failed to administer the influenza and pneumonia vaccine for residents who signed a consent form to receive influenza and pneumonia vaccines for 2 of 5 residents reviewed for infection control (Resident #33 and Resident # 54). The findings included: a. Resident #33 was admitted to the facility on [DATE]. Review of Resident #33's medical record revealed Resident's responsible party signed a Consent/Release form for the Flu Vaccine and the Pneumonia Vaccine on 12/29/23. There was a check mark on the line that read yes for the flu and pneumonia Vaccines are given annually unless medically contraindicated. I authorize the administration of the flu and pneumonia vaccine based upon educational materials which includes the risks and benefits given by the facility. Resident #33's admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #33 had moderate cognitive impairment. Review of medical record for Resident # 33 revealed no information of Resident receiving the influenza and/or the pneumonia vaccines. b. Resident #54 was admitted to the facility on [DATE] and discharged to the hospital on 01/29/24 and readmitted to the facility on [DATE]. Resident #54's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #54 was cognitively intact. Review of Resident #54's medical record revealed Resident's responsible party signed a Consent/Release form for the Flu Vaccine and the Pneumonia Vaccine on 01/17/24. There was a check mark on the line that read yes for the flu and pneumonia Vaccines are given annually unless medically contraindicated. I authorize the administration of the flu and pneumonia vaccine based upon educational materials which includes the risks and benefits given by the facility. Review of medical record for Resident #54 revealed no information of Resident receiving the influenza and/or the pneumonia vaccines. An interview was conducted on 03/14/24 at 03/14/24 at 1:38 pm with the Infection Preventionist and she indicated she had just started working in the facility a couple of weeks ago, but she had audited the vaccinations and was getting ready to obtain consents and administer the vaccines. She indicated she did not know why Resident #33 and Resident #54 did not receive their vaccines. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/14/24 03:12 PM an interview was conducted with the Director of Nursing (DON), and she indicated she started in January of this year and once the consent was signed the residents should have receive the requested vaccine. She indicated she did not know why Resident #33 and Resident #54 did not receive their vaccines.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41579 Based on record review and staff interviews the facility failed to include documentation in the medical record of education regarding the benefits and potential side effects of the COVID-19 immunization for 5 of 5 residents (Resident #46, Resident #14, Resident #26, Resident #33, and Resident #54) and offer the COVID-19 vaccine for 3 of 5 residents (Resident #26, Resident # 33, and Resident #54) and maintain a resident's record of COVID-19 vaccine history for 3 of 5 residents (Resident #26, Resident #33, and Resident #54), the failures regarding education, offering the vaccine, and maintain records were found for 5 of 5 residents reviewed for infection control. The findings included: a. Resident #46 was admitted to the facility on [DATE]. Review of a significant change Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #46 was cognitively intact. Review of Resident #46's medical record revealed no information the Resident or legal representative was provided information about the benefits and potential side effects of the COVID-19 immunization. b. Resident #14 was readmitted to the facility on [DATE]. Review of admission Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #14 was cognitively intact. Review of Resident #14's medical record revealed no information the Resident or legal representative was provided information about the benefits and potential side effects of the COVID-19 immunization. c. Resident #26 was admitted to the facility on [DATE]. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #26 had cognitive impairment. Review of Resident #26's medical record revealed no information the Resident or legal representative was provided information about the benefits and potential side effects of the COVID-19 immunization and no information about Resident #26 being offered and/or received the COVID-19 vaccine. d. Resident #33 was admitted to the facility on [DATE]. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #33 had cognitive impairment. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #33's medical record revealed no information the Resident or legal representative was provided information about the benefits and potential side effects of the COVID-19 immunization and no information about Resident #33 being offered and/or received the COVID-19 vaccine. e. Resident #54 was admitted to the facility on [DATE], discharged to the hospital on 01/29/24 and readmitted to the facility on [DATE]. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #54 was cognitively intact. Review of Resident #54's medical record revealed no information the Resident or legal representative was provided information about the benefits and potential side effects of the COVID-19 immunization and no information about Resident #54 being offered and/or received the COVID-19 vaccine. An interview was conducted with the Infection Preventionist on 03/14/24 at 1:38 pm and she indicated she had been employed in the facility for 1 1/2 weeks and had researched in the North [NAME] (NC) Vaccine Registry the vaccines for the current residents and had checked the consents to see which Residents had consents had. She indicated some consents were in the computer and some were on paper, but now she was not able to locate the consents and or education regarding the COVID-19 vaccine for any residents and the Director of Nursing (DON) was trying to locate them. On 03/14/24 at 3:12 pm an interview was conducted with the DON, and she indicated she believed the consents were being done, however they were unable to locate them. The DON indicated the vaccine process was started on admission. She indicated they would check the record, and if a resident had been given the vaccine it was documented the computer, and if they have not received the vaccine, it was offered to them, and they received education about the vaccination. She stated the consents were obtained and the vaccine would be administered.