STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345138	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Universal Health Care/Lenoir	322 Nuway Circle Lenoir, NC 28645

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37019 Based on record reviews, resident, family member, and staff interviews, the facility failed to treat a resident in a respectful and dignified manner when 1 of 3 staff (Nurse Aide (NA) #3) failed to change the resident resulting in a bowel movement that filled his brief, pooled in his wheelchair and dripped onto the floor for 1 of 3 residents reviewed for dignity and respect (Resident #1). Resident #1 indicated it made him feel bad to have bowel movement on him, his wheelchair and the floor. The findings included: Resident #1 was readmitted to the facility on [DATE]. Resident #1's Care Area Assessment (CAA) dated 10/01/23 revealed he was alert and oriented and able to make some needs known to staff. Resident #1 was incontinent of bowel and bladder and dependent on staff for incontinent care. The resident was also dependent on staff for personal hygiene, shaving, hair care, oral care, and trimming and cleaning nails. Resident #1's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed he was moderately cognitively impaired but could make some needs known. The assessment also revealed Resident #1 was total care and required the assistance of one to two staff with all activities of daily living. Review of a concern form completed 08/01/24 at 8:00 PM revealed on that date Resident #1's family member found resident soiled with bowel movement running out of the wheelchair onto the floor and his call bell was on the bedside table behind his wheelchair out of his reach. The resident was cleaned, and according to the concern report action taken staff received one on one education by the Director of Nursing (DON). Staff were educated on proper rounding and call bell placement by the DON. The concern form further indicated random checking of the resident would be done to ensure proper incontinent care was provided. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 08/04/24 at 11:45 AM with Resident #1 and his family member revealed Resident #1 had called the family member on 08/01/24 at 7:00 PM and told her that he had not been changed for three hours and had bowel movement running out of his brief, on his chair and onto the floor. The family member stated she arrived at the facility around 7:15 PM and found the resident sitting in his wheelchair with bowel movement in his chair, running down between his legs onto the floor. She stated she found Nurse #1 and told her the resident was in a mess in his chair. Nurse #1 came in and observed Resident #1 and left the room to find his Nurse Aide (NA) to let her know that he needed to be changed and to find out why he had not been previously changed. When Resident #1 was asked how he knew it had been hours since he was changed, he stated he looked at the time on his cell phone. He stated if he didn't have his call bell and it was out of his reach, he had to call his sister to call the facility to let them know that he needed care because he could not yell for help. When asked how it made him feel to be sitting in bowel movement and not being changed, he stated it made him feel bad. An interview on 08/06/24 at 3:27 PM with Nurse #1 revealed Resident #1's family member had come to her on 08/01/24 around 7:15 PM and told her that Resident #1 was in a mess in his room and explained that he had bowel movement in his wheelchair that had leaked out of his brief and was running down between his legs onto the floor. Nurse #1 stated she asked the family member if he was still in a mess and the family member told her he was so Nurse #1 went into the room and stated that she had found Resident #1 soiled with bowel movement that had pooled in his wheelchair around him and was running between his legs down onto the floor. Nurse #1 stated she went to find Nurse Aide (NA) #3 who was assigned to care for Resident #1 during the 3:00 PM to 11:00 PM shift. Nurse #1 explained that she could not find NA #3, so she found NA #6 and NA #7 and asked them to change the resident. Nurse #1 further explained that about that time NA #3 came around the corner of the hall with a mechanical lift and supplies to clean the resident. Nurse #1 said NA #3 and NA #6 got the resident back to bed, cleaned him up and cleaned his wheelchair and the floor and made sure his call light was within his reach prior to leaving his room. A telephone interview on 08/07/24 at 8:40 AM with NA #3 who was assigned to care for Resident #1 on 08/01/24 during the 3:00 PM to 11:00 PM shift revealed on that day (08/01/24) it had been extremely busy with call lights going off and said she was waiting for him to ring his call light to be changed. She admitted that she had been so busy that she had not been in to check on him since reporting to work at 3:00 PM but said she was waiting for him to ring his call light when he needed to be changed. NA #3 recalled that Nurse #1 had found her and told her he was in a mess and needed to be changed and told her that his family member was in the room. She stated she went to find a lift and to find someone to help her get him back to bed so she could change him and when she had come back to his room there were 2 NAs (NA #6 and NA #7) in the room. NA #3 said she and NA #6 got him cleaned up and said that she should have checked on him when she had gotten to the facility, but she was waiting for him to ring his call light not knowing that it had been placed out of his reach on the bedside table behind his wheelchair. An interview on 08/07/24 at 8:47 AM with NA #6 revealed she had worked on 08/01/24 during the 3:00 PM to 11:00 PM shift and had been asked by Nurse #1 to assist with cleaning Resident #1 up around 7:15 PM. She stated she and NA #7 had gone into the room to get him ready to be cleaned up when NA #3 came in the room with the mechanical lift and supplies to clean him. NA #6 said when she went into the room Resident #1 was sitting in his wheelchair with bowel movement that had leaked out of his brief all around him in the wheelchair and had dripped down onto the floor. NA #6 said she stayed in the room with NA #3 and helped her get the resident cleaned up and they cleaned up his wheelchair and the floor. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 08/07/24 at 11:05 AM with the Director of Nursing (DON) revealed she was still in the building on 08/01/24 when the incident with Resident #1 being in a mess with bowel movement had occurred. She stated Nurse #1 had come to her and told her what had happened and said she and the Staff Development Coordinator had done one on one education with the three NAs who had been working on Resident #1's hall that evening. The DON further stated the three NAs had been educated on proper rounding every 2 hours and call bell placement before leaving the resident's room. She indicated they would be continuing to monitor for rounding and call bell placement and that all residents should be treated with dignity and respect and have their needs met. An interview on 08/07/24 at 11:20 AM with the Administrator revealed that it was her expectation that residents be rounded on and checked every 2 hours and changed as needed. She stated she also expected every resident's call light to always be within their reach, so they have a way to alert staff of their needs and that they are treated respectfully and in a dignified manner while their needs are met. The Administrator further stated they were continuing to monitor rounding and call light placement.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36217 Based on observation, record review, and interviews with resident and staff, the facility failed to ensure dependent residents could access the light switch located behind their bed for 2 of 2 residents reviewed for accommodation of needs (Resident #36 and Resident #57). a. Resident #36 was admitted to the facility on [DATE]. Review of Resident #36's medical records revealed she had moved to her current room on 11/22/22. The annual Minimum Data Set (MDS) dated [DATE] coded Resident #36 with a moderately impaired cognition. The MDS indicated walking between locations inside the room for more than 10 feet was not attempted by Resident #36 during the assessment period due to medical condition or safety concerns. During an observation conducted on 08/04/24 at 1:36 PM, the switch for the light fixture behind Resident #36's bed on the wall approximately 5 feet from the floor and 6 feet from the bed was attached with a cord approximately 4 inches in length. Resident #36 was unable to reach the light switch cord from the bed if needed. An interview was conducted with Resident #36 on 08/04/24 at 1:38 PM. She stated she was bedbound and had been staying in this room for over a year. She could not recall when the light switch cord had broken, and she had never mentioned her concern to any staff so far. She did not have any control of the light fixture behind her bed as she could hardly stand up to reach the broken light switch cord on the wall. She had to rely on nursing staff to control the light fixture and she was tired of asking for help repeatedly. She wanted the maintenance staff to fix the light switch cord to accommodate her needs as soon as possible. Subsequent observations conducted on 08/05/24 at 10:20 AM and 08/06/24 at 11:43 AM revealed the light switch cord for the light fixture behind Resident #36's bed remained inaccessible. b. Resident #57 was admitted to the facility on [DATE]. Review of Resident #57's medical records revealed he had moved to his current room on 06/05/24. The annual MDS dated [DATE] coded Resident #57 with a severely impaired cognition. The MDS indicated walking between locations inside the room for more than 10 feet was not attempted by Resident #57 during the assessment period due to medical condition or safety concerns. During an observation conducted on 08/05/24 at 10:36 AM, the switch for the light fixture behind Resident #57's bed on the wall approximately 5 feet from the floor and 7.5 feet from his bed was attached with a cord approximately 4 inches in length. Resident #57 was unable to access the light switch cord from the bed if needed. An interview was conducted with Resident #57 on 08/05/24 at 10:38 AM. He did not know how long the light switch cord had been broken and added it would be great if the maintenance staff could fix it now. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Subsequent observations conducted on 08/06/24 at 11:45 AM revealed the light switch cord for the light fixture behind Resident #57's bed remained inaccessible. During a joint observation conducted with Nurse Aide (NA) #5 and Nurse #7 on 08/06/24 at 11:52 AM, the light switch cords for the light fixture behind Resident #36's and Resident #57's bed remained inaccessible from their beds. Both nursing staff acknowledged that the switch cords needed to be fixed immediately. An interview was conducted with NA #5 on 08/06/24 at 11:59 AM. She stated she worked in 200 halls frequently and had provided care for Resident #36 and Resident #57 on a regular basis. She did not notice the light switch cords for the light fixtures behind both Residents' beds were broken and inaccessible from their bed. She stated the light fixture behind residents' bed should always be accessible. During an interview conducted with Nurse #7 on 08/06/24 at 12:03 PM, she explained she did not work in 200 halls frequently and that was why she did not notice the light switch cords for the light fixture behind Resident #36's and Resident #57's beds were broken and inaccessible from their beds. She added it was important for all the residents to have full control and accessibility to the light fixture behind the bed all the time. An interview was conducted with the Maintenance Manager on 08/06/24 at 12:08 PM. He stated he walked through the entire facility several times per day routinely to look for repair needs. He did not notice the light switch cords for Resident #36's & Resident # 57's light fixtures behind their beds were broken during his daily walk through. In most cases, he depended on the staff to report repair needs via work orders electronically or verbal notifications. He checked the work orders from his phone at least twice daily to ensure all repair needs were addressed in a timely manner. He could not explain why he missed the switch cords for both residents and acknowledged that they had to be fixed immediately. During an interview conducted on 08/06/24 at 12:20 PM, the Director of Nursing (DON) expected the staff to be more attentive to residents' living environment, and to report repair needs to the maintenance department in a timely manner to accommodate residents' needs. It was her expectation for all the dependent residents to have full accessibility and control of the light fixture behind the bed all the time. An interview was conducted on 08/06/24 at 4:13 PM with the Administrator. She expected nursing staff to pay attention to residents' homes and reported repair needs to the maintenance department in a timely manner.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36217 Based on record review and interviews with staff, residents, and the Medical Director (MD), the facility failed to protect residents' rights to be free from misappropriation of controlled medication for 9 of 9 residents reviewed for misappropriation of resident property (Resident #5, #13, #36, #45, #49, #59, #336, #337, and #338). The findings included: The facility's Abuse Prevention, Intervention, Reporting, and Investigation policy, last revised on [DATE], revealed in part the facility would ensure all residents were free from misappropriation of property. The initial allegation report dated [DATE] revealed the facility became aware of the incident on [DATE] at 8:00 AM when the Administrator was notified about discrepancies identified between declining narcotic count sheets and medication administration records (MARs) for 6 residents with the potential of drug diversion. The 5-day investigation report dated [DATE] revealed the facility completed audits for all the declining narcotic count sheets and MARs from February through [DATE], with focus on the dates when Nurse #6 had worked on [DATE] and [DATE]. More discrepancies between the declining narcotic count sheets and MARs were identified and it involved 17 tablets of controlled medications for 9 residents. The 2 affected residents who reported not receiving medications as ordered were assessed on [DATE] and confirmed without suffering any harm or changes in condition. The allegation of diversion of residents' drugs was substantiated and Nurse #6 was terminated on [DATE]. The facility filed reports to the local law enforcement, North Carolina Board of Nursing (NC BON), and Drug Enforcement Agency (DEA) on [DATE]. The MD and the affected residents or their Responsible Parties were notified on [DATE]. The incident report revealed the facility submitted a complaint against Nurse #6 to NC BON and reported theft or loss of controlled substances to DEA via Form 106 on [DATE]. All the Residents were in the facility when the incident occurred on [DATE]. Residents #336, #337, and #338 were not in the facility when the surveyor started the investigation on [DATE]. a. Resident #5 was admitted to the facility on [DATE] with diagnoses including chronic pain syndrome. The physician's order dated [DATE] revealed Resident #5 had an order to receive one tablet of Norco (a type of opioid analgesic consisted of hydrocodone/acetaminophen that acted on the central nervous system to relieve pain) ,d+[DATE] milligrams (mg) by mouth once every 12 hours for pain. The declining narcotic count sheets indicated Nurse #6 had signed out one tablet of Norco ,d+[DATE] mg for Resident #5 on [DATE] at 3:00 AM and another tablet of Norco at 9:00 AM. The MAR revealed Resident #5 had received one tablet of Norco ,d+[DATE] mg on [DATE] at 8:00 AM. The Norco signed out by Nurse #6 at 3:00 AM was not documented in the MAR. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The staff roster dated [DATE] indicated Nurse #6 was working from 7:00 AM to 3:00 PM. She was not scheduled to work on [DATE] at 3 AM. The quarterly Minimum Data Set (MDS) dated [DATE] coded Resident #5 with an intact cognition. During an interview conducted with Resident #5 on [DATE] at 2:29 PM, she denied she had ever received Norco from any nurses at 3:00 AM. She recalled one of the management staff had notified her in March that her Norco could have been diverted by a nurse working in the facility at that time. b. Resident #13 was admitted to the facility on [DATE] with diagnoses including chronic pain syndrome. The physician's order dated [DATE] revealed Resident #13 had an order to receive one tablet of Percocet (a potent semisynthetic opioid that consisted of oxycodone/acetaminophen that acted on the central nervous system to relieve pain) ,d+[DATE] mg by mouth 4 times per day at 12 AM, 6 AM, 12 noon, and 6 PM. The MAR indicated Resident #13 had received one tablet of Percocet ,d+[DATE] mg on [DATE] at 12:00 AM, 6:00 AM, 12:00 PM, 6:00 PM. The declining narcotic count sheets revealed Nurse #6 had signed out one tablet of Percocet ,d+[DATE] mg on [DATE] at 12:00 PM and another tablet at 1:00 PM for Resident #13. The 1:00 PM dose of Percocet , d+[DATE] mg was not scheduled, and not charted in the MAR by Nurse #6. The quarterly MDS dated [DATE] coded Resident #13 with an intact cognition. An interview was conducted with Resident #13 on [DATE] at 9:34 AM. She recalled a management staff notified her about ,d+[DATE] months ago that a nurse had signed out a tablet of her Percocet that was not ordered and it could have been diverted. She could not provide any additional details related to the incident. c. Resident #36 was admitted to the facility on [DATE] with diagnoses including polyneuropathy, chronic pain syndrome. The physician's order dated [DATE] revealed Resident #36 had an order to receive one tablet of Norco , d+[DATE] mg by mouth once every 8 hours as needed for pain. The MAR indicated Resident #36 had received one tablet of Norco ,d+[DATE] mg on [DATE]. The MARs did not indicate Resident #36 had received any Norco on [DATE]. The declining narcotic count sheets revealed one tablet of Norco ,d+[DATE] mg was signed out by Nurse #6 for Resident #36 on [DATE] at 12:00 PM and another tablet at 8:00 PM. The blister card was emptied out by Nurse #6 on [DATE]. According to the staffing roster, Nurse #6 was not scheduled to work on [DATE]. The quarterly MDS dated [DATE] coded Resident #36 with a moderately impaired cognition. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with Resident #36 on [DATE] at 1:38 PM. She recalled a management staff notified her about a potential drug diversion related to her pain medications a few months ago but she could not recall the details. d. Resident #45 was admitted to the facility on [DATE] with diagnoses including chronic pain syndrome. The physician's order dated [DATE] revealed Resident #45 had an order to receive one tablet of Percocet 7XXX,d+[DATE] mg by mouth once every 6 hours as needed for pain. The MAR indicated Resident #45 had received one tablet of Percocet 7XXX,d+[DATE] mg as needed on [DATE] at 9:32 AM administered by Nurse #6. The declining narcotic count sheets for [DATE] revealed Nurse #6 had signed out one tablet of Percocet 7XXX,d+[DATE] mg for Resident #45 on [DATE] at 7:00 AM and another tablet at 8:00 AM. Then, one more tablet on [DATE] and 2:30 PM. The staffing roster revealed Nurse #6 was not scheduled to work on [DATE]. According to the incident report dated [DATE], Resident #45 stated he never took his as needed Percocet since it was initiated in [DATE]. He denied requesting or receiving any Percocet from any nurses on [DATE] or [DATE]. The quarterly MDS dated [DATE] coded Resident #45 with an intact cognition. During an interview conducted with Resident #45 on [DATE] at 11:37 AM, he stated he had never requested or received his as needed Percocet since it was initiated in [DATE]. He denied requesting or receiving any Percocet from any nurses on [DATE] or [DATE]. e. Resident #49 was admitted to the facility on [DATE] with diagnoses including chronic pain syndrome. The physician's order dated [DATE] revealed Resident #49 had an order to receive one tablet of Percocet , d+[DATE] mg once every 6 hours as needed for pain for 7 days. This order was discontinued on [DATE]. According to the staffing records, Nurse #6 worked first shift on the 200 hall on [DATE]. The declining narcotic count sheets dated [DATE] indicated Nurse #6 had signed out two tablets of Percocet , d+[DATE] mg for Resident #49 at 9:00 AM. The MAR for February 2024 revealed Resident #49's order for Percocet ,d+[DATE] mg was discontinued on [DATE] and the two tablets of Percocet ,d+[DATE] mg signed out by Nurse #6 were not documented in Resident #49's medical records. The quarterly MDS dated [DATE] coded Resident #49 with an intact cognition. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview conducted on [DATE] at 8:38 AM, Resident #49 could not recall the incident that occurred so many months ago. He stated he had received all his pain medication as ordered in the past 6 months and denied he had ever suffered any pain due to availability of his pain medications. f. Resident #59 was admitted to the facility on [DATE] with diagnoses including chronic pain syndrome. The physician's order dated [DATE] revealed Resident #59 had an order to receive one tablet of Norco , d+[DATE] mg by mouth 3 times per day at 6 AM, 2 PM, and 8 PM. The MAR indicated Resident #59 had received one tablet of Norco ,d+[DATE] mg as ordered on [DATE] at 6:00 AM, 2:00 PM, and 8:00 PM. The declining narcotic count sheets revealed five tablets of Norco ,d+[DATE] mg had been signed out for Resident #59 on [DATE] with one tablet signed out by Nurse #6 at 9:00 AM. The 9:00 AM dose was not documented in the MAR. The quarterly MDS dated [DATE] coded Resident #59 with a severely impaired cognition. An attempt to interview Resident #59 on [DATE] at 9:49 AM was unsuccessful. She was unable to engage in the interview. g. Resident #336 was admitted to the facility on [DATE] and expired in the facility on [DATE]. Her diagnoses included chronic pain syndrome and major depressive disorder. The physician's order dated [DATE] revealed Resident #336 had an order to receive one tablet of Norco , d+[DATE] mg by mouth once every 8 hours as needed for pain. She also had an order dated [DATE] to receive one tablet of alprazolam (a type of benzodiazepine acted on the brain to produce calming effect) 0.5 mg on Monday, Wednesday, and Friday prior to dialysis. The declining narcotic count sheets indicated Nurse #6 had signed out one tablet of Norco ,d+[DATE] mg on [DATE] at 8:00 AM and 3:00 PM, and one tablet of Alprazolam 0.5 mg on [DATE] at 9:00 AM for Resident #336. The MAR revealed both Norco and alprazolam were not documented as administered on [DATE]. Resident #336 was not scheduled to receive alprazolam on [DATE] as it was Saturday. h. Resident #337 was admitted to the facility on [DATE] and discharged on [DATE]. His diagnoses included chronic pain. The physician's order dated [DATE] revealed Resident #337 had an order to receive one tablet of Norco 7XXX,d+[DATE] mg by mouth once every 8 hours for pain. The declining narcotic count sheets dated [DATE] indicated Nurse #6 had signed out one tablet of Norco 7XXX,d+[DATE] mg for Resident #337 at 10:00 AM instead of the scheduled time of 2:00 PM. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The MAR revealed Resident #337 had received one tablet of Norco 7XXX,d+[DATE] mg as scheduled on [DATE] at 6:00 AM, 2:00 PM, and 10:00 PM. The Norco signed out by Nurse #6 on [DATE] at 10:00 AM was documented in the MAR as administered at 2:00 PM that day. According to the incident report dated [DATE], Resident #337 reported to the Unit Manager (UM) #1 that he did not receive his scheduled afternoon pain medication on [DATE] as ordered. Instead, Resident #337 stated he received a pill from Nurse #6 that looked very different in shape and color from the Norco he used to receive around 2:00 PM that day. i. Resident #338 was admitted to the facility on [DATE] and expired in the facility on [DATE]. Her diagnosis included gout. The physician's order dated [DATE] revealed Resident #338 had an order to receive one tablet of oxycodone 5 mg by mouth once every 6 hours as needed for pain. The declining narcotic count sheets indicated one tablet of oxycodone 5 mg had been signed out by Nurse #6 for Resident #338 on [DATE] at 9:00 AM, 6:00 PM, and 8:00 PM. Resident #338's MAR for February 2024 revealed all three tablets of oxycodone signed out by Nurse #6 on [DATE] were not documented. An attempt to conduct a phone interview with Nurse #6 on [DATE] at 11:18 AM was unsuccessful. The phone number was no longer in service. During an interview conducted on [DATE] at 1:36 PM, Unit Manager (UM) #1 stated on [DATE] in the afternoon around 3:00 to 4:00 PM, Resident #337 reported he had received a tablet of Norco from Nurse #6 that looked very different from the pill he used to receive. When she started to investigate Resident #337's concerns, she noticed multiple discrepancies had been charted by Nurse #6 in the declining narcotic count sheets. Then, she recalled when she took over Nurse 6's medication cart on [DATE] at around 3:00 PM, she noticed one blister card of Norco ,d+[DATE] mg for Resident #36 had been zeroed out by Nurse #6 prior to the shift transition. She remembered working the second shift on [DATE], [DATE], and [DATE] and confirmed the blister card of Norco for Resident #36 was not emptied on [DATE] or [DATE] when she counted it at the end of the shift. She became suspicious and reported the incident to the Director of Nursing (DON) immediately. On [DATE] in the afternoon, she assessed the two affected Residents (Resident #45 and Resident #337) who had reported not receiving medications as ordered on that day and confirmed both residents did not suffer any adverse consequences or changes in condition. The DON started the investigation on [DATE] at night by auditing the declining narcotic count sheets and MARs for all the residents who had received care from Nurse #6 on [DATE]. The DON found out that the discrepancies were much more massive than they initially appeared to be. She did not participate in any of the further investigations after that. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with the DON on [DATE] at 4:15 PM. She stated the incident started with a concern reported by Resident #337 to UM #1 that he had received a pill from Nurse #6 on [DATE] around 2:00 PM that looked very different from the pain pill he used to receive. Review of declining narcotic count sheet revealed the pain medication was signed out at 10:00 AM instead of 2:00 PM as ordered. Further review of the declining narcotic count sheets revealed numerous discrepancies had been charted by Nurse #6 such as opioids signed out as being given within one hour of each other where they were scheduled four times per day, opioids signed out numerous times by Nurse #6's when she was not scheduled to work, and narcotic signed out after the order was discontinued or outside of the routine for residents. It was reported that Nurse #6 left the facility for lunch and did not return for an hour on [DATE] from 1:30 PM to 2:30 PM. When the Administrator called Nurse #6 on [DATE], she kept referring to residents refusing their medications, and it was hard to get her to understand the issues related to questionable entries documented on the declining narcotic count sheets that were not present prior to her working in the facility on [DATE] and [DATE]. Nurse #6's employment at the facility was officially terminated on [DATE]. She instructed UM #1 to notify the MD, affected residents or their Responsible Parties on [DATE]. UM #1 immediately assessed the 2 affected Residents whose pain medications were not received as ordered (Resident #45 and Resident #337) on [DATE] and all the residents who could be affected by the incident on the same day. None of the residents had shown any adverse consequences. The facility filed reports to the local police department, NC BON, North Carolina Health Care Personnel Registry (NC HPR), and DEA on [DATE]. She started the in-service to educate all the licensed nurses and medication aides regarding Misappropriation of Personal Property and the Narcotic Process Policy on [DATE] and it was completed by [DATE]. All the missing controlled medications were replaced at the cost of the facility on [DATE]. During an interview conducted on [DATE] at 8:29 AM, the MD stated he did not start his employment in the facility until [DATE]. However, he was made aware of the incident that occurred on [DATE] when he started the role as the MD and provided with the list of residents affected. He stated all the affected residents were assessed immediately without any adverse consequences noted as the missing drugs were used as needed basis and the facility had adequate supply of the missing narcotic medications when it occurred. He added all the missing medications were replaced and paid for by the facility later. The facility provided the following corrective action plan with a completion date of [DATE]: Address how corrective actions will be accomplished for those residents to have been affected by the deficient practices: On [DATE] at approximately 10:30 PM, the Administrator was alerted by the Director of Nursing (DON) to some questionable entries on the declining narcotic count sheets. At least 1 resident receiving care from Nurse #6 had reported not receiving narcotics as ordered that day. The concerns identified were reported to Nurse #6's employer, which was a staffing agency. She was suspended from employment at the facility and reportedly other agencies associated with them. Nurse #6's employment was terminated at the facility on [DATE]. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In attempting to receive a statement from Nurse #6, the Administrator spoke to her over the telephone on [DATE] and tried to get her to understand the discrepancies found on the narcotic records. However, Nurse #6 only wanted to focus on residents refusing medications despite the Administrator attempted repeatedly to explain that refusing medications was not the issue. The agency representative also reported that he was unable to get Nurse #6 to understand the discrepancies. A report of the misappropriation of the residents' property was submitted to the North Carolina Health Care Personnel Registry (NC HCPR) on [DATE]. The MD and residents affected by the incident and/or their responsible parties were notified on [DATE]. The facility reported the incident to the local law enforcement agency, Drug Enforcement Agency (DEA), and North Carolina Board of Nursing (NC BON) on [DATE]. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: The 2 residents who did not receive medication as ordered were assessed immediately by a licensed nurse on [DATE]. No negative outcomes for the 2 residents were noted as the pain medications were ordered on as needed basis and the facility still had those pain medications remaining in the medication cart. All residents who received controlled pain medications were assessed for pain [DATE]. It included signs and symptoms of pain both verbal and non-verbally to ensure pain levels were being addressed appropriately. All residents have the potential to be affected by this incident. On [DATE], a 100% audit of all medication carts was completed to verify that all narcotics medications and declining narcotic count sheets were accounted for. During this audit several other discrepancies documented by Nurse #6 were discovered. The facility expanded the audit to the previous dates when Nurse #6 had worked on [DATE], and it revealed a few more discrepancies. The discrepancies varied from narcotic signed out by Nurse #6 in the declining narcotic count sheets when she was not on duty, narcotics signed out outside of normal routines and not administered, and extra doses signed out without an order. The missing medications were replaced and paid for by the facility on [DATE]. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On [DATE] education was provided by the Administrator, or DON, for all licensed nurses and medication aides regarding Misappropriation of Personal Property and the Narcotic Process Policy that focused on storing, maintaining, and returning of controlled medications to the pharmacy. This in-service included the process for shift-to-shift count, verifying medications on hand, and returning discharged residents' or discontinued medications to the pharmacy. The DON would continue to maintain and monitor controlled medication records to ensure consistency and accountability. Education was completed on [DATE] for all the nurses and medication aides, including agency staff. Licensed nurses or medication aides would not be allowed to work after [DATE] until education was completed. Education would be added to the new hire package to be reviewed with new employees during orientation. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An ad hoc Quality Assurance and Performance Improvement (QAPI) meeting was held on [DATE] with the MD, DON, and the Administrator. The Regional Director of Operations and Regional Clinical Consultant joined the QAPI meeting via Teams. The DON, Assistant Director of Nursing or Unit manager started auditing the medication carts 5 times per week for 4 weeks beginning [DATE]. Then once per week for 4 weeks to verify the narcotic count was correct on each cart, shift-to-shift count was completed appropriately, and discontinued controlled medications were removed from the medication cart and returned to the pharmacy in a timely manner. Findings would be reported to the QAPI committee monthly for 2 months for suggestions and/or recommendations until substantial compliance was achieved. Date of Compliance: [DATE] The facility's corrective action plan with a correction date of [DATE] was validated onsite by observations and interviews with the DON, Administrator, and nursing staff. An observation was conducted during a shift transition for a medication cart between 2 nurses on [DATE]. Nurses started with counting the total number of blister cards that contained controlled medication stored in the double-locked compartment in the medication cart and verified the balance in the narcotic count logs. Then, they counted each blister card of controlled medication to ensure the quantity listed in the declining narcotic count sheets were consistent with the actual counts. After all the counts were completed without any discrepancies, the incoming nurse signed the narcotic count logs before the outgoing nurse passed the medication cart key to her. Medication Administration observations that consisted of 27 medications, 3 different residents, and 3 nurses were conducted on [DATE]. All the medications were administered as ordered without any issues. Controlled medication was observed retrieving from the double-locked compartment in the medication cart during the observation. The nurse documented the retrieval of controlled medication in the declining narcotic count sheets as ordered. Random samples of 3 controlled medications were pulled from each medication cart for verification of accuracy. The controlled substance counts were consistent with the records documented in the declining narcotic count sheets. Interviews with the nursing staff including medication aides and agency nurses confirmed they had received in-service training related to Misappropriation of Personal Property and the Narcotic Process Policy. It included the process for shift-to-shift controlled medication count, verification of on-hand controlled medications, and returning of discharged residents' or discontinued medications to the pharmacy. Nursing staff were assigned to review the handout prior to the training, and it was conducted in-person by DON with multiple examples. The nurses or medication aides were able to describe the policy and procedures and verbalized understanding of this in-service education. Review of audit records revealed all residents receiving controlled medications were audited by the DON, Assistant Director of Nursing (ADON), or Unit Manager 5 times per week for 4 weeks beginning [DATE]. Then once per week for 4 weeks to ensure the narcotic count was correct on each cart, shift-to-shift count was completed appropriately, and discontinued controlled medications were removed from the medication cart and returned to the pharmacy in a timely manner. Findings were reported by the DON to the QAPI committee monthly for 2 months for suggestions and/or recommendations until substantial compliance was achieved. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the DON and Administrator revealed the facility launched an in-service related to controlled medication process and accountability immediately after the incident to re-educate all the licensed nurses and medication aides. The DON audited the medication cart in-person randomly to ensure all controlled medication counts were conducted appropriately and the declining narcotic count sheets were documented properly. Both stated the interventions were successful as the facility did not have any similar diversion issues since then. The compliance date of [DATE] was validated.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37019 Based on record reviews and resident, family member, and staff interviews, the facility failed to provide incontinence care when staff failed to change a resident resulting in a urine soaked brief, incontinence pad, sheet, and mattress for 1 of 3 residents (Resident #1) on two consecutive night shifts (11:00 PM to 7:00 AM) and when staff failed to change a resident resulting in a bowel movement that filled his brief, pooled in his wheelchair and dripped onto the floor for 1 of 3 residents reviewed for activities of daily living (ADL) (Resident #1). The findings included: Resident #1 was readmitted to the facility on [DATE] with diagnoses which included muscle wasting, lack of coordination, osteoarthritis and abnormal posture. Resident #1's Care Area Assessment (CAA) dated 10/01/23 revealed he was alert and oriented and able to make some needs known to staff. Resident #1 was incontinent of bowel and bladder and dependent on staff for incontinent care. The resident was also dependent on staff for personal hygiene, shaving, hair care, oral care, and trimming and cleaning nails. Resident #1's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed he was moderately cognitively impaired but could make some needs known. The assessment also revealed Resident #1 was total care and required the assistance of one to two staff with all activities of daily living. Review of Resident #1's care plan dated 05/16/24 revealed a focus area for the resident requiring assistance with activities of daily living related to impaired physical mobility related to dependence on staff for repositioning and transfers related to cerebral palsy, scoliosis, muscle weakness, osteoarthritis and muscle spasms. The interventions included encourage resident to ring call light for assistance, keep overbed table locked and within reach and always keep items such as cell phone within reach, and skin monitoring weekly per nursing and during ADL care. a. Review of a concern form dated 07/27/24 and 07/28/24 revealed on the day shifts (7:00 AM to 3:00 PM) Resident #1 was found wet with urine through his brief, incontinence pads, sheets and onto the mattress on both mornings and the sheets under the resident had brown rings on them. The resident was provided incontinence care and a complete bed change on both mornings. According to the concern report action taken administration provided re-education to staff on 07/30/24 regarding proper rounding and incontinence care. The report also stated that on several occasions staff reported the resident was not voiding on the 11:00 PM to 7:00 AM shift. A statement completed by NA #4 read that she had taken care of the resident on 07/27/24 on the 11:00 PM to 7:00 AM shift and that the resident had not voided all night, and this was reported to Nurse #2. The concern form indicated the resolution was ongoing. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 08/04/24 at 11:45 AM with Resident #1 and his family member revealed Resident #1 had been found on the mornings of 07/27/24 and 07/28/24 soaked with urine through his brief, incontinence pads and through the sheet onto the mattress. The family member stated she arrived at the facility early those mornings and found the resident soaked in urine. She stated she found Nurse #1 and told her the resident was soaked through his brief, pad, sheet and onto his mattress with urine. The family member further stated Nurse #1 came in and observed Resident #1's sheet not only wet with urine but with brown rings on it as though the sheet had been wet previously and not changed. The family member indicated Nurse #1 went and found NA #8 who was assigned to care for Resident #1 on the 7:00 AM to 3:00 PM shift on 07/27/24 and 07/28/24 and had her provide incontinence care and a complete bed change on both mornings. An interview on 08/06/24 at 3:27 PM with Nurse #1 revealed Resident #1's family member had come to her on the mornings of 07/27/24 and 07/28/24 and told her that Resident #1 was soaked with urine through his brief, incontinence pad, sheet and onto his mattress. Nurse #1 stated she went into his room and observed his sheet on both mornings with brown rings on the sheet that looked as though the sheet had not been changed when it was originally wet. Nurse #1 said she went and found NA #8 and asked her to change the resident on both mornings. Nurse #1 further stated on the morning of 07/29/24 she and Nurse #2 who had taken care of Resident #1 on the 11:00 PM to 7:00 AM shift went into his room that morning to check him to see if he had received care through the night and he was clean and dry. A telephone interview was attempted several times with NA #8 who had taken care of Resident #1 on the 7:00 AM to 3:00 PM shift on 07/27/24 and 07/28/24 with no return call. A telephone interview on 08/08/24 at 8:38 AM with Nurse #2 who had taken care of Resident #1 on the 11:00 PM to 7:00 AM shift on 07/27/24 and 07/28/24 revealed she remembered hearing something about the resident not being changed on the night shift. She stated she was not aware of any issues previously with NA #4 who had been assigned to care for Resident #1 on both night shifts on 07/27/24 and 07/28/24 not changing residents. Nurse #2 further stated she recalled NA #4 reporting to her on 07/28/24 that he was a no void, so she and Nurse #1 had checked Resident #1 on the morning of 07/29/24 to ensure he was dry. She indicated that when they had checked on him on 07/29/24 he was clean and dry, and his sheet and pad were dry. Nurse #2 said NA #4 had not indicated to her that she was not able to get all her work done on those night shifts. A telephone interview on 08/08/24 at 10:48 AM with NA #4 who was assigned to care for Resident #1 on the 11:00 PM to 7:00 AM shifts on 07/27/24 and 07/28/24 revealed she was only assigned to care for Resident #1 on weekends. She stated she didn't recall ever putting clean pads on over a wet sheet instead of changing the sheet if a resident had an accident. NA #4 further stated Resident #1 sometimes went through the night without voiding and she recorded him as a no void for the night and reported it to the nurse assigned to him. She indicated she could not remember if he was a no void for either 07/27/24 or 07/28/24 but said if he had been she would have reported it to his nurse. An interview on 08/07/24 at 11:05 AM with the Director of Nursing (DON) revealed she had been informed by the Administrator of Resident #1 being found wet through his brief, pad, sheet and onto his mattress on the mornings of 07/27/24 and 07/28/24. She stated NA #4 who had been assigned to care for the resident on those night shifts and the other NAs working on the halls had been provided education on proper rounding and incontinence care. She stated there was ongoing monitoring of residents to ensure incontinence care was being provided to them. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 08/07/24 at 11:20 AM with the Administrator revealed that it was her expectation that residents be rounded on and checked every 2 hours and changed as needed. The Administrator further stated they were continuing to monitor rounding and incontinence care. b. Review of a concern form completed 08/01/24 at 8:00 PM revealed on that date Resident #1's family member found resident soiled with bowel movement running out of the wheelchair onto the floor and his call bell was on the bedside table behind his wheelchair out of his reach. The resident was cleaned, and according to the concern report action taken staff received one on one education by the Director of Nursing (DON). Staff were educated on proper rounding and call bell placement by the DON. The concern form further indicated random checking of the resident would be done to ensure proper incontinent care was provided. An interview on 08/04/24 at 11:45 AM with Resident #1 and his family member revealed Resident #1 had called the family member on 08/01/24 at 7:00 PM and told her that he had not been changed for three hours and had bowel movement running out of his brief, on his chair and onto the floor. The family member stated she arrived at the facility around 7:15 PM and found the resident sitting in his wheelchair with bowel movement in his chair, running down between his legs onto the floor. She stated she found Nurse #1 and told her the resident was in a mess in his chair. Nurse #1 came in and observed Resident #1 and left the room to find his Nurse Aide (NA) to let her know that he needed to be changed and to find out why he had not been previously changed. An interview on 08/06/24 at 3:27 PM with Nurse #1 revealed Resident #1's family member had come to her on 08/01/24 around 7:15 PM and told her that Resident #1 was in a mess in his room and explained that he had bowel movement in his wheelchair that had leaked out of his brief and was running down between his legs onto the floor. Nurse #1 stated she asked the family member if he was still in a mess and the family member told her he was so Nurse #1 went into the room and stated that she had found Resident #1 soiled with bowel movement that had pooled in his wheelchair around him and was running between his legs down onto the floor. Nurse #1 stated she went to find Nurse Aide (NA) #3 who was assigned to care for Resident #1 during the 3:00 PM to 11:00 PM shift. She said when she found NA #3, she told her that Resident #1 was in a mess and needed to be changed so he didn't get skin breakdown, NA #3 told her that she was only one person, and it had been crazy with other lights going off and she had not had time to change him and walked off from Nurse #1. Nurse #1 said she went and reported the incident to the Director of Nursing (DON) who was still in the building, and she told Nurse #1 to go back and find someone to change the resident. Nurse #1 explained that she could not find NA #3, so she found NA #6 and NA #7 and asked them to change the resident. Nurse #1 further explained that about that time NA #3 came around the corner of the hall with a mechanical lift and supplies to clean the resident. Nurse #1 said NA #3 and NA #6 got the resident back to bed, cleaned him up and cleaned his wheelchair and the floor and made sure his call light was within his reach prior to leaving his room. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A telephone interview on 08/07/24 at 8:40 AM with NA #3 who was assigned to care for Resident #1 on 08/01/24 during the 3:00 PM to 11:00 PM shift revealed on that day (08/01/24) it had been extremely busy with call lights going off and said she was waiting for him to ring his call light to be changed. She admitted that she had been so busy that she had not been in to check on him since reporting to work at 3:00 PM but said she was waiting for him to ring his call light when he needed to be changed. NA #3 recalled that Nurse #1 had found her and told her he was in a mess and needed to be changed and told her that his family member was in the room. She stated she went to find a lift and to find someone to help her get him back to bed so she could change him and when she had come back to his room there were 2 NAs (NA #6 and NA #7) in the room. She said Resident #1 was in a mess and was in his wheelchair with bowel movement pooling around him in the chair and said it was so bad that it had leaked down onto the floor. NA #3 stated when she and NA #6 got him back to bed and started to clean him up that it was obvious that he had not been changed in some time because his brief was crumbling inside. She further stated it was obvious to her that he had not received appropriate care on the day shift (7:00 AM to 3:00 PM). NA #3 said they got him cleaned up and said that she should have checked on him when she had gotten to the facility, but she was waiting for him to ring his call light not knowing that it had been placed out of his reach on the bedside table behind his wheelchair. An interview on 08/07/24 at 8:47 AM with NA #6 revealed she had worked on 08/01/24 during the 3:00 PM to 11:00 PM shift and had been asked by Nurse #1 to assist with cleaning Resident #1 up around 7:15 PM. She stated she and NA #7 had gone into the room to get him ready to be cleaned up when NA #3 came in the room with the mechanical lift and supplies to clean him. NA #6 said when she went into the room Resident #1 was sitting in his wheelchair with bowel movement that had leaked out of his brief all around him in the wheelchair and had dripped down onto the floor. She further stated the family member was in the room with the resident and was upset that he was in such a mess. NA #6 said she stayed in the room with NA #3 and helped her get the resident cleaned up and they cleaned up his wheelchair and the floor. She agreed that his brief looked as though it had been on him for a long time and described it as being bunched up in areas and soaked with urine and bowel movement. An interview on 08/07/24 at 11:05 AM with the Director of Nursing (DON) revealed she was still in the building on 08/01/24 when the incident with Resident #1 being in a mess with bowel movement had occurred. She stated Nurse #1 had come to her and told her what had happened and said she and the Staff Development Coordinator had done one on one education with the three NAs who had been working on Resident #1's hall that evening. The DON further stated the three NAs had been educated on proper rounding every 2 hours and call bell placement before leaving the resident's room. She indicated they would be continuing to monitor for rounding and call bell placement. An interview on 08/07/24 at 11:20 AM with the Administrator revealed that it was her expectation that residents be rounded on and checked every 2 hours and changed as needed. She stated she also expected every resident's call light to always be within their reach, so they have a way to alert staff of their needs. The Administrator further stated they were continuing to monitor rounding and call light placement.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45380 Based on record review, facility activity calendar, and resident and staff interviews, the facility failed to ensure group activities were planned for outside of the facility to meet the needs of residents who expressed that it was important to them to attend group activities outside of the facility for 4 of 4 residents reviewed for activities (Resident #31, #35, #45, and #65). The residents expressed not being able to leave the facility for over a year made them feel mad, sad, at times depressed and they missed going out with the group to engage in activities, eat at restaurants, shop and socialize. The findings included: A review of the August 2024 activity calendar revealed activities for inside of the facility during the week and on the weekends. There were no activities scheduled for outside of the facility. Observation on 8/04/24 at 9:00 AM revealed the facility was located within a business and residential area that was within driving distance to numerous local and commercial shops, grocery stores, local and commercial coffee shops, fast food, and sit-down restaurants. a. Resident #31 was admitted to the facility on [DATE]. An Annual Minimum Data Set (MDS) dated [DATE] indicated Resident #31 felt that it was very important to have activities that included going outside of the facility and doing things in a group setting. The assessment further indicated Resident #31 was cognitively intact. An interview was conducted with Resident #31 on 8/06/24 at 3:05 PM during resident council meeting revealed there had not been a scheduled group activity outside of the facility since she was admitted and the resident council had requested them during their resident council meetings, and discussed with the administrator who would ask the previous owners about it and each time was told there was nothing they could do because the vans were broken and they had no other way to transport residents and not enough staff to go with them. Resident #31 stated that having to look at the same walls or only going out to the parking lot every once in a while, for ice cream and not being able to leave the facility and participate in group activities had made her feel sad and sometimes even depressed. She revealed although her family brings her outside food on occasion, she would enjoy being able to go to a restaurant and order her own food, socialize with other people outside of the facility, and shop for her own personal items instead of relying on her family or facility staff to purchase them for her. b. Resident #35 was admitted to the facility on [DATE]. An Annual Minimum Data Set (MDS) dated [DATE] indicated Resident #35 felt that it was very important to have activities that included going outside of the facility and doing things in a group setting. The assessment further indicated Resident #35 was cognitively intact. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with Resident #35 on 8/06/24 at 3:10 PM during resident council meeting revealed he had been at the facility for the past several years and there had not been a scheduled group activity outside of the facility since he was admitted . He stated they discussed it with the Activities Director and the Administrator who discussed it with the previous owners, and they were always told they were not able to schedule activities outside of the facility due to the vans being broken, not being able to transport residents, not enough staff available to go with them and the previous owners not approving for any alternate transportation. Resident #35 revealed just recently he had brought up wanting to go to a Celebration of Life event that was held locally for the elderly and was given the same excuses and he felt that would have been a good event for them to go to and be able to socialize with other people and learn about different resources available for them in the community and he didn't understand why the facility or the previous owners would not have made arrangements for them to go. He stated he had been at other facilities prior to coming there and those facilities had group outings and they were able to go places and do different activities in the community and he just didn't understand in the several years he had been there why the vans had not been fixed or why the facility had not hired more staff to go with them so they could schedule activities outside of the facility. He revealed not being able to leave the facility for scheduled group activities made him very upset and just plain mad and he was tired of hearing the same excuses and would just like to be able to go to a restaurant and order his own meal or to the store to purchase his own items instead of relying on family or staff to purchase what he needs and although the facility had been bought out by a new company he did not have much faith that things would change. c. Resident #45 was admitted to the facility on [DATE]. An Admission Minimum Data Set (MDS) dated [DATE] indicated Resident #45 felt that it was very important to have activities that included going outside of the facility and doing things in a group setting. The assessment further indicated Resident #45 was cognitively intact. An interview was conducted with Resident #45 on 8/06/24 at 3:15 PM during resident council meeting revealed since he had been at the facility there had been no scheduled activities outside of the facility. He stated during resident council meetings they had discussed with the Activities Director and the Administrator about scheduling activities outside of the facility and the Administrator would speak with the previous owners about it but they were always told that was not possible because the facility was not able to provide transportation due to the vans being broken and they did not have enough staff to go with them. He revealed not having scheduled activities outside of the facility made him feel sad and sometimes depressed and he was tired of his options being to look at the same walls inside, go sit outside in the courtyard, or occasionally go outside in the parking lot for ice cream or to watch fireworks once a year. Resident #45 stated he would like to be able to go to a restaurant to eat, go to a store, socialize with other people outside of the facility, go bowling, or really anything that would allow them the opportunity to get out of the building. d. Resident #65 was admitted to the facility on [DATE]. An Annual Minimum Data Set (MDS) dated [DATE] indicated Resident #65 felt that it was very important to have activities that included going outside of the facility and doing things in a group setting. The assessment further indicated Resident #65 was cognitively intact. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with Resident #65 on 8/06/24 at 3:20 PM during resident council meeting revealed since he had been to the facility there had been no scheduled activities outside of the facility. He stated they had discussed with the Activities Director during resident council about scheduling activities outside of the facility and the AD would go and speak with Administration who would speak with the previous owners, and they were always told that was not possible because the facility was not able to provide transportation due to the vans being broken and not having enough staff to accompany the residents. Resident #65 stated not having the opportunity to participate in activities outside of the facility made him feel sad, mad, and depressed especially since there only options were to look at the same walls inside, sit outside in the courtyard or on occasion the facility might have an ice cream social in the parking lot and they would watch fireworks from the parking lot once a year on 4th of July. He revealed he had been at other facilities before coming there and they would have activities scheduled outside of the facility each month and he didn't understand why this facility could not do something to assist with them being able to leave the facility on a group activity even once every other month or once a quarter. Resident #65 stated he would like to be able to go to a restaurant and order his own meal and socialize with other people, go to the store shopping, go bowling, and go downtown to the annual blackberry festival and to watch the Christmas parade, all of which are within 5-10 minutes from the facility. An interview was conducted with the Activity Director (AD) on 8/06/24 at 3:30 PM revealed she had been working as the AD at the facility for the past 3 years and part of her responsibilities was scheduling and implementing resident activities inside and outside of the facility for each month. She stated since she began working at the facility as the AD, she had not been able to schedule any resident group activities outside of the facility due to transportation issues. She revealed two of the facility vans had been broken since she began working at the facility and she was told the other facility van could only be used for medical appointments and residents would just have to participate in activities inside of the facility or on facility grounds. The AD stated she had brought the issue to Administration often of the residents requesting to schedule activities outside of the facility and each time the Administrator would contact the previous owners, and they were always told no due to the transportation issues, not having enough staff available to go, and alternate transportation for the residents was not available. She revealed she had been doing personal shopping for residents so they could continue to receive their preferences but understood that was not the same as the residents being able to leave the facility and shop for themselves or eat a meal together at a restaurant, go bowling, or go downtown to the festival or to watch a Christmas parade. She stated she felt like activities outside of the facility for those residents who could participate were important for their overall well- being and allowed them some independence and socialization outside of the facility. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview conducted with the Administrator on 8/07/24 at 11:36 AM revealed she had been employed at the facility as the Administrator since 2019 but had worked at the facility for 20 plus years in other roles. She stated if her memory served her right, the last scheduled group activity outside of the facility was right after she became the Administrator in 2019. She revealed not long after she became the Administrator was when two of the vans had broken and they were only allowed to use the one working van for medical appointments. The Administrator stated from the time the two vans had broken in 2019 until the facility was sold to new ownership in June 2024, she had discussed with the previous owners on a consistent basis the need to have both vans repaired so they could use them to transport residents to activities outside of the facility. She revealed each time she would discuss the matter with the previous owners, they would tell her no and would not approve spending money to fix the vans and they were not willing to pay for alternative transportation. She stated this time was also during COVID, and the facility did not have the extra staff to send out trips other than medical appointments but feels the facility has finally gotten staffing back on track where they would have the extra staff they could schedule to go out with residents on trips and still be covered in the building. The Administrator revealed new ownership took over the facility in June 2024 and she had not been able to meet with them about transportation for scheduled group activities outside of the facility but hoped they will assist her with getting the two facility vans fixed so they will be able to use those or allow them to use contract services to be able transport residents to outside group activities. She stated she was aware of the importance of her residents being able to leave the facility and go out into the community for scheduled group activities and how her residents would benefit from going to events, festivals, [NAME], restaurants, and shopping in the community and being able to socialize with other people and she was going to speak with the new ownership and do everything she could to assist with making that happen.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 48006 Based on record review and staff interview, the facility failed to schedule a Registered Nurse (RN) for at least 8 consecutive hours per day, 7 days a week for 25 of 213 days reviewed for sufficient staffing. This deficient practice had the potential to affect all facility residents. Finding included: Review of the PBJ (Payroll Based Journal) Staffing Data Report Fiscal Year - Quarter 2, 2024 (January 1 - March 31, 2024) revealed the facility had no RN coverage on 01/14/2024, 01/28/2024, 02/11/2024, 02/25/2024, and 03/24/2024. Review of the daily assignment schedules from April 1, 2024, to July 31, 2024, revealed the facility failed to provide 8 hours of RN coverage on the following dates: 04/06/2024, 04/07/2024, 04/21/2024, 05/05/2024, 05/10/2024, 05/13/2024, 05/19/2024, 06/01/2024, 06/02/2024, 06/15/2024, 06/29/204, 06/30/2024, 07/03/2024, 07/04/2024, 07/08/2024, 07/09/2024, 07/13/2024, 07/14/2024, 07/27/2024, and 07/28/2024. a. The nursing schedule for 01/14/2024 was reviewed. No RN was scheduled to work on that date. The schedule was reviewed with the Administrator who verified no RN had worked any shift on 01/14/2024. b. The nursing schedule for 01/28/2024 was reviewed. No RN was scheduled to work on that date. The schedule was reviewed with the Administrator who verified no RN had worked any shift on 01/28/2024. c. The nursing schedule for 02/11/2024 was reviewed. No RN was scheduled to work on that date. The schedule was reviewed with the Administrator who verified no RN had worked any shift on 02/11/2024. d. The nursing schedule for 02/25/2024 was reviewed. No RN was scheduled to work on that date. The schedule was reviewed with the Administrator who verified no RN had worked any shift on 02/25/2024. e. The nursing schedule for 03/24/2024 was reviewed. No RN was scheduled to work on that date. The schedule was reviewed with the Administrator who verified no RN had worked any shift on 03/24/2024. f. The nursing schedule for 04/06/2024 was reviewed. No RN was scheduled to work on that date. The schedule was reviewed with the Administrator who verified no RN had worked any shift on 04/06/2024. g. The nursing schedule for 04/07/2024 was reviewed. No RN was scheduled to work on that date. The schedule was reviewed with the Administrator who verified no RN had worked any shift on 04/07/2024. h. The nursing schedule for 04/21/2024 was reviewed. No RN was scheduled to work on that date. The schedule was reviewed with the Administrator who verified no RN had worked any shift on 04/21/2024. i. The nursing schedule for 05/05/2024 was reviewed. No RN was scheduled to work on that date. The schedule was reviewed with the Administrator who verified no RN had worked any shift on 05/05/2024. (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	j. The nursing schedule for 05/10/2024 was reviewed. No RN was scheduled to work on that date. The schedule was reviewed with the Administrator who verified no RN had worked any shift on 05/10/2024. k. The nursing schedule for 05/13/2024 was reviewed. No RN was scheduled to work on that date. The schedule was reviewed with the Administrator who verified no RN had worked any shift on 05/13/2024. l. The nursing schedule for 05/19/2024 was reviewed. No RN was scheduled to work on that date. The schedule was reviewed with the Administrator who verified no RN had worked any shift on 05/19/2024. m. The nursing schedule for 06/01/2024 was reviewed. No RN was scheduled to work on that date. The schedule was reviewed with the Administrator who verified no RN had worked any shift on 06/01/2024. n. The nursing schedule for 06/02/2024 was reviewed. No RN was scheduled to work on that date. The schedule was reviewed with the Administrator who verified no RN had worked any shift on 06/02/2024. o. The nursing schedule for 06/15/2024 was reviewed. No RN was scheduled to work on that date. The schedule was reviewed with the Administrator who verified no RN had worked any shift on 06/15/2024. p. The nursing schedule for 06/29/2024 was reviewed. No RN was scheduled to work on that date. The schedule was reviewed with the Administrator who verified no RN had worked any shift on 06/29/2024. q. The nursing schedule for 06/30/2024 was reviewed. No RN was scheduled to work on that date. The schedule was reviewed with the Administrator who verified no RN had worked any shift on 06/30/2024. r. The nursing schedule for 07/03/2024 was reviewed. No RN was scheduled to work on that date. The schedule was reviewed with the Administrator who verified no RN had worked any shift on 07/03/2024. s. The nursing schedule for 07/04/2024 was reviewed. No RN was scheduled to work on that date. The schedule was reviewed with the Administrator who verified no RN had worked any shift on 07/04/2024. t. The nursing schedule for 07/08/2024 was reviewed. No RN was scheduled to work on that date. The schedule was reviewed with the Administrator who verified no RN had worked any shift on 07/08/2024. u. The nursing schedule for 07/09/2024 was reviewed. No RN was scheduled to work on that date. The schedule was reviewed with the Administrator who verified no RN had worked any shift on 07/09/2024. v. The nursing schedule for 07/13/2024 was reviewed. No RN was scheduled to work on that date. The schedule was reviewed with the Administrator who verified no RN had worked any shift on 07/13/2024. w. The nursing schedule for 07/14/2024 was reviewed. No RN was scheduled to work on that date. The schedule was reviewed with the Administrator who verified no RN had worked any shift on 07/14/2024. x. The nursing schedule for 07/27/2024 was reviewed. No RN was scheduled to work on that date. The schedule was reviewed with the Administrator who verified no RN had worked any shift on 07/27/2024. y. The nursing schedule for 07/28/2024 was reviewed. No RN was scheduled to work on that date. The schedule was reviewed with the Administrator who verified no RN had worked any shift on 07/28/2024. (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An interview was conducted on 08/07/2024 at 08:22 AM with the facility's Administrator. The Administrator reported she was aware RN coverage was a problem. She stated that since January 1, 2024, RN coverage had been concerning especially every other weekend. The Administrator also stated the facility's scheduler had recently resigned and that she had assumed responsibility for the nursing schedule. The Administrator further stated that she had contracts with several staffing agencies but on most occasions they had not been able to provide an RN. The Administrator confirmed there were multiple days in 2024 where no RN coverage was provided, and that the facility was not meeting the expectation to be in compliance with the regulations. The Administrator also revealed that an RN was always on-call and available via telephone but not physically in the facility during the days without RN coverage. The Administrator also revealed the facility was under new management and she expected to have more staffing support which would ensure adequate RN coverage.