STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345171	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White Oak Manor - Shelby	401 N Morgan Street Shelby, NC 28150

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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** 45380 Based on record review and resident and staff interviews the facility failed to treat a resident in a dignified manner when staff assisted a resident onto the commode and left the resident. This deficient practice was for 1 of 3 residents reviewed for dignity (Resident #3). Resident #3 required extensive 1 person assist with transfers and toileting, and due to the long wait, transferred himself back to his wheelchair causing feces to get onto his clothes and wheelchair which made him feel very upset and mad. The Findings included: Resident #3 was admitted to the facility on [DATE] with diagnoses of congestive heart failure, osteoarthritis, and chronic obstructive pulmonary disease (COPD). The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #3 was cognitively intact, required substantial 1-person maximum assistance with toileting and transfers, with some incontinence of bladder and bowel. Resident #3 was assessed as requiring a wheelchair for mobility. No refusal of care was noted during the assessment reference period. A telephone interview with Resident #3's responsible person (RP) on 5/23/24 at 11:13 AM revealed the family arrived at the facility after lunch on 12/25/23 to take Resident #3 out for a visit and found him sitting outside the shower room door with his pants pulled up mid-thigh and bowel movement on him and his chair. She stated Resident #3 revealed a nursing assistant (NA) had taken him to use the commode in the shower room and left him there for what he thought was at least 40-45 minutes. She revealed Resident #3 stated that while he was on the commode he had a bowel movement, was not able to clean himself or pull his pants up all the way so he transferred himself off the commode into his wheelchair and was sitting outside of the shower room waiting for help. The RP stated the family assisted with pulling up Resident #3's pants and cleaning off the bowel movement enough to get him back to his room when the NA arrived with a fast-food bag in her hand apologizing for leaving Resident #3 on the commode. She revealed the NA then assisted Resident #3 back to the shower room to assist with cleaning him up and when she returned, she again apologized for leaving him on the commode stating she had gotten sidetracked and then had left the faciity on her lunch break. She stated Resident #3 was mad and appeared very upset and even a little bit embarrassed about the incident. She revealed she contacted the Social Work (SW) Director a couple of days later, on 12/27/23 and discussed the incident with her, filed a grievance, and the SW Director handled the matter from there and she received a letter in the mail stating the outcome. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #3 was interviewed in his room on 5/23/24 at 2:07 PM. During the interview he stated several months ago NA #2 took him to the restroom in the shower bathroom, assisted him to the commode and left the room. Resident#3 revealed he was uncomfortable and had a bowel movement and was not able to wipe himself or pull up his pants past mid-thigh, so he transferred himself back into his wheelchair and was sitting in the doorway of the shower room trying to get someone to assist him when the same NA #2 came back and looked surprised. When asked if he was exposed while sitting outside of the shower room due to only being able to pull up his pants to mid-thigh, Resident #3 stated no that his pants were still able to provide coverage and he did not feel he was exposed. The interview revealed Resident #3 had been sitting on the shower room commode for about 45 minutes. When asked how he knew it had been 45 minutes, Resident #3 stated he looked at the clock in his room prior to leaving and when he returned. He stated NA #2 apologized and said she had gotten busy and forgot she had placed him onto the commode. NA #2 took Resident #3 back to the shower room and got him cleaned up. He stated he could not recall if his family was in the building, but he had spoken with them about it afterwards. Resident #3 revealed he was upset and mad about the situation stating he doesn't like for staff to leave him because they won't come back and from now on, he doesn't let staff leave him while toileting. An interview was conducted with NA #2 on 5/23/24 at 2:15 PM. She stated she had been working 1st shift on 12/25/23 and had overheard Resident #3 ask NA #4 for assistance with going to the bathroom and NA #4 told Resident #3 she would assist him with toileting when she returned from her lunch break. NA #2 revealed she didn't want Resident #3 to have to wait that long, so she took him to the shower room, removed his brief, and assisted him onto the commode. She revealed while Resident #3 was toileting she realized there were no clean briefs in the shower room, so she left the shower room while Resident #3 was toileting to find clean briefs and was sidetracked by another resident's family asking for assistance. NA #2 stated after she finished assisting the other resident and their family, she also went on her lunch break with NA #4 and while they were at lunch talking, she realized that she had forgotten about Resident #3 and had left him on the commode in the shower room. She revealed that when she returned Resident #3 was in his room with his family, she assisted him back to the shower room and finished cleaning him up. NA #2 also revealed that from the time that she had assisted Resident #3 onto the commode, assisted the other resident and family, left for lunch, and realized that she had left him on the commode was at least 40-45 minutes. She revealed she did not recall reporting to the nursing supervisor about leaving Resident #3 on the commode and that she did not intentionally mean to leave Resident #3 on the commode and forget, it was a mistake and human error and would never happen again. Attempted to contact NA #4 on 5/23/24 who was no longer employed with the facility, and she did not return telephone calls. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/23/24 at 3:42 PM an interview was conducted with the Administrator and the DON. The DON revealed she was not made aware of the incident with Resident #3 being left on the commode in the shower room for a long period of time until the SW Director notified her of the grievance filed by his RP. The DON stated during her interviews with 1st shift staff who worked with Resident #3 on 12/25/23, she learned NA #2 and NA #4 had been involved. She revealed both NA #2 and NA #4 were very honest, forthcoming, and remorseful about the incident and she felt this was an isolated incident based on human error and there did not seem to be any malicious or ill intent to cause harm. The DON stated NA #2 was re-educated on resident care and notifying nursing supervisor of any incidents and prior to leaving for breaks and that NA #4 chose not to return to the facility prior to receiving re-education. The Administrator stated that staff should be performing patient care in a timely manner, as needed, and as requested and no resident should be left on a commode without supervision, especially residents that required assistance.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48006 Based on record review and staff interviews the facility failed to develop comprehensive care plans in the areas of anticoagulant (blood thinning) medication use for 2 of 2 residents whose comprehensive care plans were reviewed (Resident #4 and Resident #31). Findings included: 1. Resident #4 was admitted to the facility on [DATE] with diagnoses including congestive heart failure (CHF). A review of Resident #4's medical record revealed a physician's order dated 09/07/2023 for apixaban (an anticoagulant medication) 5.0 milligrams (mg) twice daily for atrial fibrillation (an irregular, rapid heartbeat which causes poor blood flow). A review of Resident #4's comprehensive care plan last revised on 03/12/24 did not reveal any care plan focus area or interventions related to receiving an anticoagulant medication. A review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #4 received anticoagulant medication during the assessment period. A review of Resident #4's April and May 2024 Medication Administration Record revealed she received apixaban 5 mg twice daily as prescribed. On 05/22/2023 at 10:13 AM an interview with the MDS Nurse revealed Resident #4's care plan did not address anticoagulant medication. She explained the care plan should include the use of an anticoagulant medication. An interview was conducted with the Regional MDS Coordinator on 05/22/2024 at 10:30 AM. The Regional MDS Coordinator stated that the quarterly MDS was accurate, but the care plan did not address Resident #4's use of anticoagulant medication. She explained the care plan should capture an accurate clinical picture of the resident and include the management of anticoagulant medications. An interview was conducted on 05/22/2023 at 11:10 AM with the Director of Nursing (DON). The DON indicated anticoagulant medications were considered high-risk medications. She stated it should be addressed in Resident #4's comprehensive care plan so all staff caring for her would be aware she was at risk for side effects like bleeding or bruising. 2. Resident #31 was admitted to the facility on [DATE]. Her diagnoses included deep vein thrombosis (blood clot in lower leg) and embolism (blood clot in the lungs). A review of Resident #31's medical record revealed a physician's order dated 09/08/2023 for apixaban (an anticoagulant medication) 5 milligrams (mg) twice daily for deep vein thrombosis and embolism. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #31's comprehensive care plan dated 09/14/2023 did not reveal any care plan focus area or interventions related to receiving an anticoagulant medication. A review of the quarterly MDS assessment dated [DATE] for Resident #31 revealed she had received anticoagulant medication during the assessment period. A review of Resident #31's April and May 2024 Medication Administration Record (MAR) revealed she received apixaban twice daily as prescribed. On 05/22/2023 at 10:13 AM an interview with the MDS Nurse revealed Resident #31's care plan did not address anticoagulant medication. She explained the care plan should include the use of an anticoagulant medication. An interview was conducted with the Regional MDS Coordinator on 05/22/2024 at 10:30 AM. The Regional MDS Coordinator stated that the quarterly MDS was accurate, but the care plan did not address Resident #31's use of anticoagulant medication. She explained the care plan should capture an accurate clinical picture of the resident and include the management of anticoagulant medications. An interview was conducted on 05/22/2023 at 11:10 AM with the Director of Nursing (DON). The DON indicated anticoagulant medications were considered high-risk medications. She stated it should be addressed in Resident #31's comprehensive care plan so all staff caring for her would be aware she was at risk for side effects like bleeding or bruising. An interview was conducted with the Administrator on 05/23/2024 at 9:16 AM. The Administrator stated she expected all resident care plans to be reflective of their clinical condition including the use of anticoagulant medications.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40476 Based on record review, staff, Nurse Practitioner and Pharmacist interviews the facility failed to clarify orders for monitoring blood pressure and pulse for the administration of an antihypertensive medication.This occurred for 1 of 5 residents reviewed for unnecessary medication (Resident #46). The findings included: Resident #46 was admitted to the facility originally on 11/15/21 with diagnosis that included hypertension. Resident #46 was readmitted into the facility on [DATE] following a hospitalization . The Minimum Data Set admission assessment dated [DATE] revealed Resident #46 was cognitively intact. A hospital discharge summary dated 03/28/24 revealed orders for Carvedilol (blood pressure medication) 12. 5 milligrams by mouth in the morning and evening. Montior heart rate and blood pressure (avoid medication if the heart rate is below 70 and blood pressure is below 120/80). A physician order dated 03/28/24 revealed an order for Carvedilol 12.5 mg 1 tablet by mouth twice a day. The order read to monitor Resident #46's blood pressure weekly and pulse daily. Resident #46's Medication Administration Record (MAR) dated April 2024 revealed the facility was monitoring the resident's pulse twice a day and blood pressure weekly. Resident #46's Medication Administration Record (MAR) dated May 2024 revealed the facility was monitoring the resident's pulse twice a day and blood pressure weekly. On 05/22/24 at 11:28 AM an interview was conducted with the Assistant Director of Nursing (ADON). During the interview she stated she was responsible for completing Resident #46's admission medication reconciliation and had entered the physician orders. She stated the facility had a standard protocol for monitoring blood pressure medication. The ADON stated the standard protocol was not written on paper, but it was, just what the facility went by. She stated if a resident was on a blood pressure medication regardless of if there were parameters or not coming from the hospital, they only monitored the residents' pulse daily and blood pressure weekly. The interview revealed she had not transcribed the order as written on the hospital discharge summary. The interview revealed she had not clarified the standard protocol with the Nurse Practitioner or Physician. On 05/22/24 at 2:15 PM an interview was conducted with the Nurse Practitioner. During the interview she stated typically for any blood pressure medication there would be parameters set to monitor the blood pressure prior to administration. She stated if the resident was getting the medication twice a day, then the blood pressure should be monitored twice daily and not just once a week. She stated from the review of Resident #46's vital signs her blood pressure remained elevated so there would have been no negative effects from the facility only monitoring once a week, but they should have followed the hospital discharge orders. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/22/24 at 4:42 PM an interview was conducted with the Pharmacist. During the interview he stated the order dated 03/28/24 was placed into the pharmacy system to hold the medication for a blood pressure less than 120/80 and heart rate less than 70. On 05/23/24 at 9:30 AM an interview was conducted with the Director of Nursing (DON). During the interview she stated the blood pressure parameters come from the pharmacy and they should have attached a parameter setting to the order. She stated it was a computer issue that the parameters had not transferred over onto the MAR for the nurses to see. The interview revealed the nursing staff should have clarified with the Nurse Practitioner or Medical Director to make sure they wanted to continue those parameters.

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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 evening and weekend group activities were planned for the facility to meet the needs of residents who expressed that it was important to them to attend group activities for 4 of 4 residents reviewed for activities (Resident #17, #23, #43, and #75). The findings included: A review of the May 2024 activity calendar revealed group activities for the facility were only scheduled in the mornings and afternoons during the week, Monday through Friday. There were no activities scheduled for evenings or weekends at the facility except for a 10:30 AM church service on Saturday mornings. a. Resident #17 was admitted to the facility on [DATE]. An annual Minimum Data Set (MDS) dated [DATE] indicated Resident #17 felt that it was very important to have activities that included inside and outside of the facility and doing things in an independent and group setting. The assessment further indicated Resident #17 was cognitively intact. An interview was conducted with Resident #17 on 5/22/24 at 10:10 AM during resident council meeting revealed there had not been scheduled evening and weekend group activities at the facility for the past 6 months. She stated the facility does offer a church service on Saturday mornings at 10:30 AM but nothing else and she would like to have some activities scheduled for the evenings and the weekends, so they had something to do other than watch television in their rooms or the dayroom. She revealed her family visits and takes her out of the facility often but not all residents have families that can do that and feels evening and weekend activities would help occupy resident time. Resident #17 also revealed not having evening and weekend activities caused her to feel bored and lonely. b. Resident #23 was admitted to the facility on [DATE]. A significant change Minimum Data Set (MDS) dated [DATE] indicated Resident #23 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 #23 was cognitively intact. An interview was conducted with Resident #23 on 5/22/24 at 10:10 AM during resident council meeting revealed she had been at the facility for several years and felt like in the past they had activities staff off and on that would come in and do activities in the evenings and weekends, but for the past 6 months at least they have had no scheduled evening and weekend activities. She stated the facility does offer a church service on Saturday mornings at 10:30 AM and usually only residents that can take themselves attend the service. She revealed she felt residents would benefit from having scheduled activities in the evenings and weekends because it would give the something to look forward to and that it gets sad and lonely in the evenings and on weekends especially if you don't have any visitors and nothing to do but watch television. When asked if she had discussed these concerns with the Activities Director, she said no because she didn't want to hurt her feelings but the other residents in resident council had discussed the issue. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. Resident #43 was admitted to the facility on [DATE]. An annual Minimum Data Set (MDS) dated [DATE] indicated Resident #43 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 #43 was cognitively intact. An interview was conducted with Resident #43 on 5/22/24 at 10:10 AM during resident council meeting revealed she enjoyed activities and for the past several months at least, there had been no activities scheduled for the evenings and weekends. She stated she often gets bored, lonely, and sometimes a little depressed especially when all she has to do in the evenings and on the weekends was watch television. d. Resident #75 was admitted to the facility on [DATE]. An annual Minimum Data Set (MDS) dated [DATE] indicated Resident #75 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 #75 was cognitively intact. An interview was conducted with Resident #75 on 5/22/24 at 10:10 AM during resident council meeting revealed for the past 6 months or longer the facility has not offered scheduled evening or weekend activities other than a church service on Saturday mornings. She stated she enjoys participating in activities because it gave her reason to get up out of bed and socialize with other residents and not having them in the evenings and on weekends, the time goes by slowly and she gets lonely, bored, and sometimes depressed. Resident #43 revealed she had not addressed her concerns with the Activities Director but had discussed them with other members of resident council and they also felt residents would benefit from having scheduled activities in the evenings and on the weekends. An interview with NA #1 on 5/22/24 at 10:00 AM revealed she had worked at the facility on both 1st and 2nd shift for the past several months and could not recall ever seeing any scheduled group activities during the evenings and on weekends. She stated some of the residents attend a church service on Saturday mornings but other than that they can watch television in their rooms or in the dayroom, read the paper, color, or do crossword puzzles if they are able. She revealed there are not enough nursing staff on nights and weekends to assist with activities, so residents basically have to find their own activities to do. An interview with NA #2 on 5/23/24 at 2:07 PM revealed she worked at the facility on both 1st and 2nd shift for the past couple of months and was not aware of any scheduled activities being offered in the evenings or weekends except for a church service on Saturday mornings. She stated most activities are scheduled during the mornings and afternoons through the week and then after that residents either have to watch television in their rooms or the dayroom or read if they are able. She revealed some of the residents have family that take them out for visits but most of them are stuck in the facility 24 hours a day and would benefit scheduled activities in the evenings and the weekends, so they have something to pass the time and feel bored and depressed. (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 with the Activities Director on 5/23/24 at 2:55 PM revealed she had been employed as the Activities Director at the facility for the past couple of years and typically worked Monday through Friday 8 AM to 5 PM. She stated she has a full-time activity assistant who works 1st shift Monday through Friday and 2 part-time assistants who also work 1st shift Monday through Friday. She revealed they have had activity assistants off and on who worked evenings but they have been hard to keep and the last one they had was in December 2023, so they have had no scheduled group activities in the evenings and on weekends since then. The Activities Director stated they do have activity packets with coloring sheets, word search puzzles, and some other different worksheets they give to nursing staff every Friday so they can be set out in the dayroom for residents to do over the weekends. She revealed they also have a church service on Saturday morning at 10:30 AM for residents who like to attend but other than that they have no other scheduled group activities during the evenings or on the weekends. She revealed she has had some residents complain about not having activities on the weekend or being bored on the weekends and she will try and set up an individual activity for them when she can. She stated she knew how important activities were to the residents and agreed they could benefit from having scheduled group activities in the evenings and on the weekends and could understand why residents could feel lonely, sad, or depressed and get bored with just watching television. The Activities Director revealed she would discuss with the Administrator possibly switching up some of the schedules or times for the activity assistants to help cover some evening and weekend activities until they could find someone to fill the position. An interview with the Administrator on 5/23/24 at 3:42 PM revealed the facility has had activity assistants, off and on, who would specifically work evenings and weekends but then they would leave and the last one they had left this past December. She stated they were currently in the process of trying to hire an activity assistant to work the evening and weekends and in the meantime would be discussing with the Activities Director about possibly changing up the times of when the other activity assistants were scheduled to see if they could cover some evening and weekend shifts until another assistant could be hired. She stated she understood scheduling resident activities for evenings and on the weekends was very important and she would try her best to accommodate those needs.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43643 Based on record review, resident interview, and staff interviews the facility failed to safely transfer a resident when Nurse Aide (NA) #3 and NA #4 transferred Resident #240 resident from the bed to the wheelchair. During the transfer the resident reported pain and stated her knee had popped. Resident #240 was sent to the emergency room (ER) and x-ray results indicated a right horizontal fracture involving the superior patella (a break in the upper part of the kneecap) with large knee joint effusion. Resident #240 was discharged back to the facility the same day with an immobilizer and a follow up appointment with .This occurred for 1 of 3 residents reviewed for supervision to prevent accidents (Resident #240). The findings included: Resident #240 was admitted to the facility on [DATE] with diagnoses which included dementia. Review of admission Minimum Data Set (MDS) dated [DATE] revealed Resident #240 was moderately cognitively impaired and was dependent for transfer and required two people assist. Review of Resident #240's Kardex which explained the resident's transfer status indicated the resident was a two person assist with a gait belt since admission on 04/25/24. Review of Resident #240's physical therapy note dated 04/26/24 revealed Resident #240 was dependent for chair to bed and bed to chair transfers and required maximal assistance for sit to stand transfers. Interview conducted with the Director of Therapy on 05/22/24 at 10:10 AM revealed Resident #240 was admitted from the hospital as a two people assist with a gait belt and was assessed on 04/26/24 by therapy and was dependent for transfers. The Director of Therapy stated the resident was limited weight bearing and continued to require two people assist with a gait belt or a Hoyer lift. The Director of Therapy further revealed transferring Resident #240 without a gait belt was unsafe and nursing staff had been educated on how to properly transfer residents. A written statement completed by NA #3 on 05/03/24 revealed on 05/02/24 NA #3 and NA #4 entered Resident #240's room and the resident was sitting on the side of the bed with family wanting to assist the resident to the bedside commode. The statement further revealed Resident #240 was okay to be transferred from the bed to the wheelchair to be weighed. NA #3 indicated before Resident #240 sat in the wheelchair she plotted down, and her leg was under the wheelchair. The statement revealed NA #3 and NA #4 took Resident #240 to be weighed and then put her back in the bed. NA #3's written statement revealed Resident #240 stated her knee was hurting and they had received a footrest for the resident's wheelchair before going to be weighed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview conducted with NA #3 on 05/21/24 at 4:20 PM revealed on 05/02/24 she and NA #4 went into Resident #240's room to get the resident to be weighed. Resident #240 was sitting in the side of the bed with family present with the bedside commode nearby when they entered the room. NA #3 indicated the family left the room and they assisted the resident from the bed to the wheelchair to be taken to get her weight. NA #3 revealed she and NA #4 stood Resident #240 by the arms without a gait belt and started to turn the resident to be able to sit down but the resident lost her balance and fell back in the wheelchair. NA #3 stated Resident #240's right foot ended up behind and underneath the chair. NA #3 revealed Resident #240 started to scream in pain and stated that her knee popped. The NA indicated Nurse #4 was notified and assessed Resident #240 and instructed NA #3 to get a leg rest for the wheelchair to put the resident ' s right leg on. NA #3 revealed Resident #240 continued to complain of pain, but they were instructed by Nurse #4 to weigh the resident after she was assessed. NA #3 indicated Resident #240 was weighed and assisted back into bed by Nurse #4 and Nurse #3. NA #3 indicated Resident should have had a gait belt when transferred and they failed to do so because they were in a hurry. A phone interview conducted with Nurse Aide (NA) #4 on 05/21/24 at 1:50 PM revealed on 05/02/24 she and NA #3 were instructed by Nurse #4 to get Resident #240's weight. NA #4 further revealed the resident was sitting on the side of the bed with family present when they entered the room. NA #4 indicated the family left the room and NA #3 and NA #4 changed Resident #240's brief and transferred the resident from the bed to the wheelchair. NA #4 stated Resident #240 stood up assisted by both NAs and when the resident went to turn the resident fell back into the chair and Resident #240's right leg was bent back behind. NA #4 indicated Resident #240 stated my knee hurts bad, and something popped. Nurse #4 assessed the resident and placed Resident #240's right leg on a wheelchair leg rest and instructed for the NAs to weigh the resident after she was assessed. NA #4 indicated Resident #240 continued to complain of pain while being weighed. NA #4 revealed Nurse #4 and Nurse #3 put the resident back to bed. NA #4 stated she and NA #3 did not use a gait belt to transfer Resident #240 because they were in a hurry and should have because the resident was unable to hold her own weight and her Kardex required a two person transfer with a gait belt. A phone interview conducted with Nurse #4 on 05/22/24 at 8:55 AM revealed on 05/02/24 a NA reported Resident #240 was complaining of leg pain and heard a pop in her leg. Nurse #4 stated she observed Resident #240 in her wheelchair and was complaining of pain in both of her legs. Nurse #4 indicated she assessed Resident #240 but could not recall if she instructed NA #3 and NA #4 to obtain a footrest, the outcome of the assessment, or if she assessed the resident before or after she was weighed. Nurse #4 indicated she did not complete an incident report but did notify the Assistant Director of Nursing (ADON) due to being at shift change. Nurse #4 was unable to share any further details of what occurred on 05/02/24 with Resident #240. A written statement completed by Nurse #3 on 05/03/24 revealed on 05/02/24 Resident #240 stated that her right knee hurt, and the RR indicated it occurred during a transfer. The statement indicated the on call was notified and a STAT (immediate) x-ray was ordered, and a lidocaine patch was placed on the resident ' s knee for pain. Nurse #3's statement indicated the family requested for Resident #240 to be sent out to the ER and the on call provided an order for the resident to be sent out. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of progress note dated 5/2/24 completed by Nurse #3 revealed Resident #240's resident representative (RR) reported the resident had complained of knee pain and that her knee popped when being transferred from the bed to the wheelchair. The on-call provider was contacted, and a STAT x-ray was ordered for Resident #240's right knee and the RR was notified. The note indicated Resident #240 received pain medication and a lidocaine patch that was applied to the knee for pain. Nurse #3 documented an estimated time of an hour and half later Resident #240's RR was concerned about the results and wanted the resident to be sent out to the hospital. The on-call was contacted again and an order was obtained to send out Resident #240 to the emergency room (ER) per RR request. A phone interview conducted with Nurse #3 on 05/22/24 at 8:30 AM revealed on 05/02/24 she arrived at the facility after the incident at shift change. Nurse #3 indicated Nurse #4 shared to monitor Resident #240's knee due to the resident stating her knee felt tight during a transfer. Nurse #3 recalled being on shift for about 45 minutes and Resident #240's RR asked her to assess Resident #240 right leg. Nurse #3 indicated Resident #240's right knee was swollen, and the resident had complained of pain. Nurse #3 further revealed she contacted and notified the on-call provider and a STAT order for an x-ray was put in. Nurse #3 revealed Resident #240's RR did not want to wait any longer and requested the resident go out to the hospital. Nurse #3 revealed on call was contacted again and the resident was sent to the ER per family request. Review of the ER report dated 05/02/24 revealed Resident #240 arrived from the facility with a right knee pain she sustained from the facility while being transferred from bed to a wheelchair. The note further revealed it was reported the resident heard a pop, and the family would like an x-ray to be completed. It was documented Resident #240 had history of osteopenia but no significant degenerative joint disease. Results of x-rays revealed an acute appearing horizontal fracture involving the superior patella (a break in the upper part of the kneecap) with large knee and joint effusion (fluid built up in between joints causing swelling). Resident #240 was discharged back to the facility on [DATE] with an immobilizer. The note indicated a referral was completed for the resident to follow up with an orthopedic provider. Review of the occurrence reported completed by Nurse #5 on 05/03/24 revealed Resident #240 went to the emergency room (ER) to have right knee evaluated which resulted in a non-displaced fracture to the right patella per report. The resident returned wearing an immobilizer and the Program of All-Inclusive Care for the Elderly (PACE) to schedule an ortho appointment. Recommended interventions revealed Resident #240 was to be changed to a total lift with two people assisting. A phone interview conducted with Resident #240 on 05/21/24 at 10:30 AM revealed she had dementia and sometimes got confused but recalled two staff members helping her get in her wheelchair from her bed. The resident stated when staff transferred her it happened fast and when she sat down in her wheelchair her knee hurt bad. The resident indicated staff pushed her out the room after it happened. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A phone interview conducted with Resident #240's resident representative (RR) on 05/21/24 at 10:40 AM revealed family had visited the resident, and two staff members came into the resident ' s room to take her to get weighed. The RR further revealed he was out in the hall and heard Resident #240 yell oh, my leg. When Resident #240 exited her room, it was observed the resident's right leg was placed in a leg rest on the wheelchair with staff pushing her to be weighed. The RR indicated staff reported that the resident's leg was not straight when she sat down, and her leg went back behind the wheelchair. The RR indicated they observed Resident #240 to have facial expressions of being in pain. The resident continued to complain of pain while they took the resident to get weighed. The RR revealed after the staff weighed Resident #240, they put the resident into bed and a Nurse assessed the resident. The Nurse stated she would keep an eye on the resident's knee to make sure it was not swelling. Interview conducted with the Assistant Director of Nursing (ADON) on 05/21/24 at 2:15 PM revealed she was not in the facility on 05/02/24 at the time of the incident and Nurse #3 contacted her and told her that Resident #240 had complained of knee pain and the RR wanted the resident sent out to the ER. The ADON advised Nurse #3 to contact the on call and provide the information. The ADON indicated she was not aware that the injury could have been as a possible result of the transfer until Monday 05/06/24 after speaking to staff. The ADON stated when Resident #240 was transferred staff should have been aware if Resident #240 ' s legs and feet were straight, and the resident legs should have not been bent behind. Interview conducted with the Director of Nursing (DON) on 05/21/23 at 2:30 PM revealed she was not present at the facility at the time of the incident and was not aware of Resident #240 was sent out to the ER until 05/03/24 during morning meeting. The DON further revealed she was not aware the NAs did not use a gait belt during the transfer. The DON stated Resident #240 was a dependent two person assist with gait belt and a gait belt should have been used. The DON indicated if a gait belt was used and used properly the resident wouldn't have fallen in the wheelchair. The DON revealed no in service or education was conducted with staff after the incident because she was not aware the transfer was not done correctly.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40476 Based on record reviews, staff, Nurse Practitioner and Pharmacist interviews the facility failed to obtain a routine medication from the pharmacy for administration which caused a resident to miss 28 doses of the medication for 1 of 5 residents (Resident #46) reviewed for unnecessary medication. The findings included: Resident #46 was admitted to the facility originally on 11/15/21 with diagnoses that included hyperlipidemia. Resident #46 was readmitted into the facility on [DATE] following a hospitalization . The Minimum Data Set admission assessment dated [DATE] revealed Resident #46 was cognitively intact. Resident #46's hospital discharge summary dated 03/28/24 revealed orders for Atorvastatin 40 mg by mouth every morning for high cholesterol. A physician order dated 03/29/24 revealed an order for Atorvastatin 40 mg by mouth once daily at bedtime. Resident #46's Medication Administration Record (MAR) dated April 2024 revealed an order for Atorvastatin 40 mg by mouth once daily at bedtime. The order was documented as not given on 14 of the 31 days during the month by Medication Aide #1. Resident #46's Medication Administration Record (MAR) dated May 2024 revealed an order for Atorvastatin 40 mg by mouth once daily at bedtime. The order was documented as not given on 14 of the 21 days during the month by Medication Aide #1. On 05/22/24 at 11:28 AM an interview was conducted with the Assistant Director of Nursing (ADON). During the interview she stated she was responsible for completing Resident #46's admission medication reconciliation and had entered the physician orders. The interview revealed when she entered Resident #46's Atorvastatin there was a pharmacy box in the computer system that she had not checked when completing the admission. She stated the order had not been sent to the pharmacy to fill the medication by mistake. On 05/22/24 at 9:00 AM an interview was conducted with Medication Aide #1. During the interview she stated she was typically the MA assigned to administer Resident #46's medication Monday through Friday. She stated the medication came to the facility prepackaged for each resident. The interview revealed since Resident #46 returned to the facility from the hospital she had not had Atorvastatin 40 mg to administer to the resident. She stated she had told the Staff Development Coordinator (SDC) she did not have the medication to give and the SDC told her she would call the Pharmacy. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/22/24 at 10:33 AM an observation was conducted with the Staff Development Coordinator (SDC) of the 100-hall medication cart. The SDC pulled from the cart Resident #46's prepackaged medication for the day. Atorvastatin 40 mg was not included in the medication for the resident. She stated she did recall MA #1 telling her they did not have the medication several weeks ago and she let Nurse #2 know to call the pharmacy. On 05/22/24 at 10:42 AM an interview was conducted with Nurse #2. During the interview she stated the SDC had come to her and stated they did not have the medication Atorvastatin 40 mg for Resident #46. She stated she called the pharmacy and spoke with someone on the phone who said they would refill the order and then hung up the phone. She stated she had not followed up to see if the medication had come to the facility. On 05/22/24 at 10:42 AM an interview was conducted with the Pharmacy Staff Member #1. During the interview she stated the pharmacy had never filled the order for Atorvastatin 40 mg because when the resident was readmitted into the facility the nurse completing the admission had not checked the box in the computer system to send the order to the pharmacy to be filled. She stated she could not see any reports in the system from the facility requesting a refill of the prescription. On 05/22/24 at 2:15 PM an interview was conducted with the Nurse Practitioner. The NP stated the facility should have ensured the resident had her medication as ordered. However, Atorvastatin 40 mg was not significant and would not be a medication that had to be tapered off. She stated the resident would have had no side effects from not receiving it since 03/28/24. On 05/22/24 at 4:42 PM an interview was conducted with the Pharmacist. The Pharmacist stated he did not feel Resident #46's would have had any side effects from not receiving Atorvastatin 40 mg. He stated the medication could be stopped abruptly and effects from not taking the medication would not be seen from missing one month or two months dose. The interview revealed the pharmacy had never received the order for the medication from the facility. On 05/23/24 at 9:30 AM an interview was conducted with the Director of Nursing (DON). The DON stated after reviewing the orders for Atorvastatin 40 mg in the computer system she realized the ADON had never checked the box to send the order for the medication to the pharmacy. She stated the medication had not been filled by pharmacy since 03/28/24 after Resident #46 returned from the hospital. She stated Medication Aide #1 should have come to her directly when she realized she had not been giving the resident the medication for over a month.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45380 Based on observations, resident and staff interviews the facility failed to provide evening snacks to residents when requested for 4 of 4 residents (Resident #17, #23, #43, and #75) reviewed for frequency of snacks. This practice had the potential to affect other residents who requested or desired an evening snack. The findings included: a. Resident #17 was admitted to the facility on [DATE] with diagnosis that included type 2 diabetes and heart failure. An annual Minimum Data Set (MDS) dated [DATE] indicated Resident #17 was cognitively intact. An interview with Resident#17 during resident council meeting on 5/22/24 at 10:15 AM revealed since she had been at the facility she could not recall if she had ever received an evening snack or been offered an evening snack consistently. She stated sometimes when you ask for things from nursing staff, especially in the evenings, they will forget to bring it back to your room. She revealed sometimes her family would provide her with snacks, but she would like staff at the facility to offer her a snack in the evenings and she was not aware of snacks being available to her in the nourishment room. b. Resident #23 was admitted to the facility on [DATE] with diagnosis that included type 2 diabetes and heart failure. A significant change MDS dated [DATE] indicated Resident #23 was cognitively intact. An interview with Resident #23 during resident council meeting on 5/22/24 at 10:15 AM revealed during her stay at the facility she might have been offered or received an evening snack on occasion but not on a consistent basis. Resident #23 revealed she would like to be offered and receive an evening snack because sometimes she does get hungry after dinner, but she didn't like to bother staff by asking them to get her things and she wasn't aware that snacks were available in the nourishment room for her to be able to get on her own. c. Resident #43 was admitted to the facility on [DATE] with diagnosis that included anemia and hypertension. An annual MDS dated [DATE] indicated Resident #43 was cognitively intact. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with Resident #43 during resident council meeting on 5/22/24 at 10:15 AM revealed during her stay at the facility she did not recall ever being offered or receiving an evening snack. She stated sometimes the dinner portions are small and she gets hungry later in the evening and would like to be offered an evening snack. She revealed she had no knowledge of the facility having a nourishment room with snacks and drinks for residents or where the nourishment room was even located. Resident #43 stated her family does provide her with snacks when she asks but she doesn't always want to ask them to bring her things and felt the facility should offer an evening snack. d. Resident #75 was admitted to the facility on [DATE] with diagnosis that included type 2 diabetes and heart failure. An annual MDS dated [DATE] indicated Resident #75 was cognitively intact. An interview with Resident #75 during resident council meeting on 5/22/24 at 10:15 AM revealed since she had been at the facility she might have received an evening snack a couple of times but not on a consistent basis. She stated she did not always have the money to be able to purchase her own snacks and didn't want to have to ask her family to purchase her snacks all the time and she felt the facility should be able to provide her with an evening snack when requested. Resident #75 revealed when she has asked staff about receiving a drink or an evening snack, they would usually forget to come back with her snack, and she wasn't always able to get up and get her own snack from the nourishment room. An observation of nourishment room on 5/20/24 at 10:30 AM revealed the refrigerator to have sandwiches, drinks, and thickened liquid juices. There were bagged snacks, snack cakes, cookies, crackers, sugar free pudding, sugar free Jello, and sugar free cookies located in the cabinet of the room. An interview with Dietary Manager #1 on 5/20/24 at 10:00 AM revealed he had been employed at the facility for several months and part of dietary staff responsibilities were to make sure the nourishment room was stocked at all times with sandwiches, drinks, thickened liquid juices, snacks, and sugar free snacks. He revealed that dietary staff, including himself, checked the nourishment room during each shift and had been educated on making sure the nourishment room was stocked with snacks, sandwiches, and drinks to be available for residents and staff. Dietary Manager #1 stated nursing staff also had access to replenish snacks and drinks for the nourishment room if needed and the facility always had an overstock of snacks and drinks available. He revealed to his knowledge there had been no complaints of the nourishment room running out of snacks and drinks, but he was not aware if staff were offering residents evening snacks. An interview with NA #1 on 5/23/24 at 10:00 AM revealed she worked both 1st and 2nd shift and had never seen evening snacks being offered to residents, she had never offered evening snacks to residents, and had never been told to offer evening snacks to residents. She stated if a resident asked for a snack, then staff would get them one, but she wasn't sure if most residents were aware they could request a snack, that snacks were supposed to be offered, or where the nourishment room was even located to get their own snack. She revealed no issues with the nourishment room not having an ample supply of snacks, sandwiches, and drinks available for residents, she believed staff just were not aware that were supposed to be offering an evening snack to all residents. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with NA #2 on 5/23/24 at 2:07 PM revealed she worked both 1st and 2nd shift at the facility. She stated to her knowledge staff do not offer residents evening snacks but if a resident requested a snack, they would provide them with one. She stated she was not really sure why staff did not offer evening snacks; she had been working at the facility for several months and had never been told to offer evening snacks to residents and had never seen other staff offering evening snacks. She revealed it would make sense to offer residents an evening snack because not all residents are able to request an evening snack, and some require certain types of snacks or liquids based on their diets. NA #2 stated she did not recall residents complaining about not receiving an evening snack, but she was also not sure if most residents were aware staff should be offering an evening snack, could request an evening snack, or where the nourishment room with snacks and drinks available was located. An interview with NA #3 on 5/23/24 at 2:20 PM revealed she typically worked 1st shift at the facility but has worked 2nd shift on occasion and did not recall staff offering residents evening snacks. She stated during 1st shift she will offer afternoon snacks to her residents especially those that cannot request a snack or require a modified snack or liquid due to their dietary needs. She revealed she did not know if staff on 2nd shift were not aware they should be offering evening snacks or if they just chose not to because the nourishment room was always stocked with assorted snacks, sandwiches, and drinks. An interview with the Administrator on 5/23/24 at 3:42 PM revealed she expected there to always be snacks available and offered to residents. The Administrator further revealed dietary staff should be stocking enough snacks, sandwiches, and drinks for residents and nursing staff should have notified dietary staff, nursing supervisors, the DON or herself if there was an issue with not having evening snacks available for residents. The Administrator indicated nursing staff could have asked the Director of Nursing or Unit Managers for the codes to the nourishment rooms. She stated the facility orders an adequate amount of snacks each month to make sure residents have a variety of options for their snacks and there was no reason why residents should not be offered or receiving their evening snacks.