| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345193 | A. Building<br>B. Wing | 04/17/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Mountain View Manor Nursing Ce | 410 Buckner Branch Road<br>Bryson City, NC 28713 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37014<br><br>Based on record review and staff interviews, the facility failed to treat a resident in a dignified and respectful manner when Nurse Aide #1 raised her voice, yelled and argued with a resident causing the resident to become upset for 1 of 3 residents reviewed for dignity (Resident #122). A reasonable person would not want to be yelled at and could feel belittled, scared or threatened when spoken to in such an undignified manner.<br><br>Findings included:<br><br>Resident #122 was admitted to the facility on [DATE].<br><br>The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #122 had moderate impairment in cognition. He had no behaviors and required assistance with toileting hygiene and transfers.<br><br>Review of the facility's investigation documentation revealed on 08/28/24, Nurse #2 and Nurse Aide (NA) #2 reported they witnessed NA #1 display verbal aggression toward Resident #122 by yelling and arguing with him after he had fallen while attempting to go to the bathroom unassisted. When NA #2 continued arguing back and forth with Resident #122, Nurse #2 intervened and removed NA #1 from the room. Corrective actions included mandatory inservice for all staff on residents rights, neglect, abuse and exploitation. In addition, NA #1 was immediately suspended and her employment subsequently terminated on 09/02/24 following the completion of the facility's investigation.<br><br>Resident #122 discharged from the facility on 11/26/24 and was unable to be interviewed.<br><br>An undated witness statement written by NA #1 revealed in part that on 08/28/24 after Resident #122 had fallen in the bathroom she asked him why he had attempted to go to the bathroom unassisted and Resident #122 started shouting at NA #1 stating that was what she told him to do. NA #1 noted in the statement that she denied telling that to Resident #122 and in an attempt to defend myself, I did raise my voice. NA #1 further noted in the statement, I admit I shouldn't have spoken loudly to any resident, I feel that it could have been handled better by all parties involved.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a phone interview on 04/16/25 at 4:54 PM, NA #1 recalled on the evening of 08/28/24, NA #2 called her to the room because Resident #122 had fallen on the bathroom floor and the door wouldn't open. NA #1 stated she managed to wedge herself through the door to get it open for Nurse #2 and NA #2 to come in. When Nurse #2 asked Resident #122 what happened, Resident #122 started yelling and screaming at her (NA #1) stating that she had told him to go to the bathroom. NA #1 stated she responded by telling Resident #122 that what he was saying was not true and she never told him to take himself to the bathroom. NA #1 stated she never cursed or yelled at Resident #122 but did disagree with what he was telling Nurse #2. NA #1 stated she was asked to leave the room by Nurse #1, was sent home that night and a few days later she was notified her employment was terminated.<br><br>During a phone interview on 04/16/25 at 4:28 PM, Nurse #2 confirmed she had worked at the facility on 08/28/24 during the hours of 7:00 PM to 7:00 AM and recalled being notified that Resident #122 had fallen on the bathroom floor. Nurse #2 stated she couldn't recall the exact specifics of what happened but did remember as she entered Resident #122's bathroom, NA #1 came in behind her and stood over Resident #122 with one leg on each side of him. Nurse #2 stated when she asked Resident #122 what happened, he looked at NA #1 and stated he only did what she (NA #1) told him to do, which was to get up off his butt and go to the bathroom. Nurse #2 recalled NA #1 then started screaming and cursing stating she never said anything like that to Resident #122. Nurse #2 stated Resident #122 was upset, so she intervened instructing NA #1 to leave the room and called the Nurse Supervisor to let her know what had happened. Nurse #2 stated after NA #1 left the room and staff assisted Resident #122 up off the floor and back to bed, he calmed down and returned back to his baseline.<br><br>During a phone interview on 04/17/25 at 9:48 AM, NA #2 revealed she witnessed the incident involving Resident #122 and NA #1 on 08/28/24. NA #2 stated at the time, she was a Personal Care Assistant (PCA) and was going room-to-room with NA #1 helping with what she could. NA #2 recalled early in the shift on 08/28/24 around 5:00 PM, she went into Resident #122's room with NA #1 because he had wet the bed. She recalled Resident #122 had recently returned from the hospital and wasn't feeling well. NA #2 stated NA #1 started getting snippy (irritable) with Resident #122 and asking him various questions such why he hadn't used the urinal like he used to and why he didn't just get up and go to the bathroom. NA #2 couldn't recall the exact time but stated it was sometime later in the shift when she had checked in on Resident #122 and found him lying on the bathroom floor and called for NA #1 to come to the room. NA #2 stated she and Nurse #2 were both present when NA #1 raised her voice when asking Resident #122 why he was in the bathroom. NA #2 stated when Resident #122 told NA #1 that he was just doing what she had told him to do, NA #1 started yelling at Resident #122 stating she never told him to do that. NA #2 stated Resident #122 was upset that he had fallen and NA #1 talking and arguing with him the way she did just upset him further. NA #2 stated NA #1 never cursed at Resident #122 but she was being very disrespectful and argumentative toward Resident #122.<br><br>During an interview on 04/17/25 at 3:22 PM, the Administrator revealed it was never appropriate for staff to speak to residents disrespectfully. He explained if residents were resistive or upset, staff were instructed to walk away from the situation and get another staff member to try and provide the resident's care. The Administrator explained at the time of the incident with Resident #122, NA #1 was going through a lot of personal issues which he felt likely contributed to her losing control of her behavior and speaking disrespectfully to Resident #122 but it should have never escalated to the point that it did. The Administrator stated he did not feel that NA #1 was verbally abusive to Resident #122 but she was definitely disrespectful, which was never acceptable. |

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| F 0602<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from the wrongful use of the resident's belongings or money.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47683<br><br>Based on record review and interviews with staff, the facility failed to protect resident rights to be free from misappropriation of controlled medication for 1 of 7 residents reviewed for misappropriation of resident property (Resident #276).<br><br>The findings included:<br><br>Review of the facilities Abuse, Neglect and Exploitation policy and procedure which was last reviewed on 4/4/25 revealed that the facility stated residents had the right to be free from misappropriation of property.<br><br>Resident #276 was admitted to the facility on [DATE] with diagnosis that included depression, anxiety disorder and dementia.<br><br>Review of the quarterly minimum data set (MDS) dated [DATE] revealed that Resident #276 was severely cognitively impaired.<br><br>Review of the physician's order dated 10/16/24 revealed Resident #276 had an order to receive 0.5 milligrams (MG) of lorazepam (a medication used to treat anxiety) every 6 hours as needed for anxiety for 14 Days.<br><br>Review of the facilities investigation dated 10/26/24 revealed at 9:00 PM on 10/25/45 the Administrator in Training (AIT) was comforting Resident #275. Upon leaving the resident's room the AIT discovered 2 white pills. The AIT took the lorazepam pills to the nurse on the hall Nurse #6. At around 10:00 PM to 10:15 PM the AIT asked Nurse #6 if she had solved the issue with the pills found in Resident #275's room. Nurse #6 stated she was going to waste the pills with another nurse, Nurse #3. Nurse #6 then confirmed the medication did not belong to Resident #275. At 10:15 PM on 10/25/24 Nurse #3 was asked to count narcotics with Nurse #6. The count was completed and there were two narcotics that needed to be fixed/ corrected. The pills were punched out and Nurse #6 stated that she was going to take the pills to the resident that needed them. At 4:50 AM Nurse #7 was reviewing the narcotic count sheet. Nurse #7 found that a controlled medication was marked as wasted and another medication was signed out, but no one was documented as having witnessed the waste. Nurse #7 reached out to Nurse #6 who was still in the building catching up on charting from her shift. Nurse #7 had noted suspicious activity for Resident #276 controlled medication. Nurse #7 then informed the AIT of the suspicious activity. At 5:00 AM on 10/26/24 Nurse #3 was asked to sign for 2 pills that were wasted by Nurse #6. Nurse #3 signed off on the narcotic sheet that the 2 white pills were wasted. The AIT then suspended Nurse #6 pending an investigation. The facility then interviewed Nurse #3, Nurse #6, and Nurse #7 and sent Nurse #6 for a drug test on 10/28/24. Resident # 276's medication administration record (MAR) was reviewed, and it was documented that the controlled medication was as needed and last administered in August 2024. The allegation of diversion of residents' drugs was substantiated and Nurse #6 was terminated on 10/29/24. The facility filed a report to the North Carolina Board of Nursing (NC BON) on 10/29/24. The investigation was documented by the AIT.<br><br>(continued on next page) |

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| F 0602<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the controlled medication count sheet revealed that Nurse #6 had signed out one tablet of lorazepam 0.5 MG for Resident #276 on 10/25/24 at 9:00 PM and then documented it as a wasted punch and another tablet of lorazepam at 9:00 PM and then documented it as a wasted punch. Nurse #3 signed off as having witnessed the wasting of both tablets of lorazepam.<br><br>Review of Resident #276's October 2024 Medication Administration Record (MAR) revealed the prn lorazepam was not initialed administered.<br><br>A phone interview with Nurse #3 was attempted several times without success. This Nurse no longer worked at the facility.<br><br>A phone interview with Nurse #6 was attempted several times without success. This Nurse no longer worked at the facility.<br><br>A phone interview with Nurse #7 was attempted several times without success. This Nurse no longer worked at the facility.<br><br>An interview with the AIT on 4/17/25 at 10:24 AM revealed she arrived at the facility at 9:00 PM on 10/25/24 to sit and meet with Resident #275. She sat with Resident #275 for 45 minutes to an hour. She got up and spoke to Nurse #6 to tell her she calmed Resident #275 down. She went back into Resident #275's room and found a little white pill with EP904 on it in his bed. She took the pill to Nurse #6, and Nurse #6 snatched it out of the AIT's hand and placed it in a little plastic medication cup and placed that in the top drawer of Nurse #6's medication cart. The AIT stated that she went back into Resident #275's room and saw a second little white pill with EP904 on it on the ground next to Resident #275's shoe. She took that second pill to Nurse #6 and asked her what it was. She stated that Nurse #6 told the AIT she wasn't supposed to see that and took the pill from her. Nurse #6 then stated that she would waste the medication after she finished her medication pass. The AIT stated that she googled EP904 and discovered the medication was lorazepam. She stated that when Nurse #7 came in between 10:00 PM to 10:30 PM the AIT asked Nurse #7 to verify if Resident #275 had an order for lorazepam. Nurse #7 informed the AIT that Resident #275 did not have an order for lorazepam. Nurse #7 looked at the controlled medication count sheet for Resident #275 and stated that the documentation was incomplete and asked if Nurse #6 was still at the facility. The AIT told Nurse #7 that Nurse #6 was still there. Nurse #7 stated that she was going to go take care of it with Nurse #6. The AIT stated that Nurse #7 confronted Nurse #6 about correcting the controlled medication count sheet. She stated that Nurse #7 said Nurse #6 had first asked her to sign the witness section for the two wasted lorazepam tablets. Nurse #7 stated that she had refused as she was not present during the wasting of the lorazepam. The AIT explained Nurse #6 then took the controlled medication count sheet to Nurse #3 and asked her to sign the witness for the lorazepam waste that Nurse #6 stated she had completed earlier in the night. Nurse #3 signed off the witness signature for the 2 lorazepam tablets Nurse #6 stated she had wasted. The AIT the called the Administrator and the former Director of Nursing (DON) immediately. The AIT stated that she then asked Nurse #3 if she had witnessed Nurse #6 wasting the 2 lorazepam tablets earlier. Nurse #3 stated no she didn't see the pills get wasted and she knew she shouldn't have signed off on the controlled medication count sheet. The AIT revealed that Nurse #6 had already left at this point and the former DON called Nurse #6 to let her know she was suspended pending an investigation. On Monday 10/28/24 she sent Nurse #6 to get a drug test, and they terminated Nurse #6 on 10/29/24 after their investigation was completed.<br><br>(continued on next page) |

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| F 0602<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A phone interview with the former Director of Nursing (DON) on 4/17/25 at 2:03 PM revealed that the AIT informed her that she had found lorazepam in Resident #275's room and gave it to Nurse #6. She stated that she was partially involved in the investigation, and she had confirmed that Resident #276 had the orders for the lorazepam. She and the AIT called Nurse #6 together to interview her during the facilities investigation and asked her to take a drug test on 10/28/24.<br><br>An interview with the Administrator on 4/17/25 at 2:58 PM revealed that 2 of Resident #276's lorazepam pills were found in Resident #275's room on his bed and on the floor beside his shoe and Resident #275 did not have an order for lorazepam. He stated that the facility opened an investigation, reported Nurse #6 to the Board of Nursing, and suspended Nurse #6. He stated that ultimately, they ended up terminating Nurse #6. He indicated that was all the information he had about that investigation. |

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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement policies and procedures to prevent abuse, neglect, and theft.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47683<br><br>Based on record review and staff interviews, the facility failed to implement their abuse policy and procedure by not maintaining evidence of an investigation into misappropriation of property and not immediately reporting an allegation of abuse to the Administrator/designee and not notifying local law enforcement or Adult Protective Services of allegations of abuse or misappropriation of property for 3 of 5 abuse investigations reviewed (Residents #12, #24, #27, #43, #223, #222).<br><br>The findings included:<br><br>Review of the facilities Abuse, Neglect and Exploitation policy and procedure which was last reviewed on [DATE]. The administrator will be immediately notified by staff if abuse, neglect, mistreatment, misappropriation and or exploitation is alleged or suspected. Staff will document the investigation findings including any recommendations of corrective action and such documentation will be retained as part of the investigation file.<br><br>a. Review of the initial allegation report submitted by the facility to the State Agency noted an allegation type of misappropriation of resident property that the facility was made aware of on [DATE] at 4:52 PM that noted the medications of Resident #12, Resident #24, Resident #27, and Resident #43 were found in Nurse #8's personal bag at the nurse's station. The facility attempted to notify Nurse #8 of her suspension and local law enforcement were notified of misappropriation of resident property.<br><br>A review of the facility's investigation documentation revealed that Nurse #8 had removed the medications from the cart because the residents no longer used the medications or they were expired. The investigation consisted of a statement from Nurse #8 and interviews conducted with alert and oriented residents asking if they were happy with their care, if staff was treating them with dignity and respect, and if the nurses provided care including medications in a professional manner. There was no additional information included in the facility's investigation such as the names of the medications or amount of medications for each resident that was found in Nurse #8's personal bag.<br><br>Several attempts were made to interview Nuse #8 with no success. She no longer worked at the facility.<br><br>A phone interview with the former Director of Nursing (DON) on [DATE] at 2:03 PM revealed that she had been the DON for approximately 2 months when this incident occurred. She stated that she saw a bag at the nursing station and when she checked the bag, there were resident medications inside. She stated that she started the initial report to submit to the State Agency and notified the Social Worker, Administrator and Corporate. The former DON explained as part of the investigation, she got a statement from Nurse #8, notified the physician, monitored the residents for adverse reactions, got a list of medications that were found, and initiated a plan of correction. In addition, she obtained drug screen from Nurse #8, notified local authorities, notified the resident's responsible parties and or the residents. She stated that she had completed a thorough investigation and was unsure why none of the documentation for all the things she completed was gone.<br><br>(continued on next page) |

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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An interview with the Administrator on [DATE] at 3:01 PM revealed that the former DON stated that some staff brought the bag with the resident medications in them to her. He stated that the investigation was a reportable to the State Agency and there was an attempt to interview Nurse #8. He stated that he was uncertain of what steps were completed as part of this investigation and had no idea where the missing documentation for the investigation might be.<br><br>A phone interview with the former Corporate Nurse on [DATE] at 3:41 PM revealed that as part of the investigation, all she did was ask the alert and oriented residents about their care and medication administration and no residents had reported any issues. She stated that she was normally the one who returned medications to pharmacy for destruction but she could not recall if she returned the medications that were found in Nurse #8's bag. The Corporate Nurse stated she was unsure where any additional documentation related to the investigation would be located.<br><br>39037<br><br>b. Review of the initial allegation report submitted by the facility to Division of Health Service Regulation (DHSR) via fax transmission on [DATE] at 5:40 PM noted an allegation of diversion of resident drugs that the facility was made aware of on [DATE] 3:30 PM. It was alleged that a possible diversion of medication had occurred due to Resident #223's liquid Morphine being an abnormal color. The allegation was not reported to law enforcement.<br><br>Review of the 5-day investigative report submitted by the facility to DHSR via fax transmission on [DATE] at 9:25 AM noted Adult Protective Services (APS) was not notified of the allegation. Further review revealed the allegation of diversion of resident drugs was unsubstantiated.<br><br>An interview with the Social Worker (SW) on [DATE] at 3:02 PM revealed she completed the 24-hour/5-day report for the allegation of possible diversion of Resident #223's liquid Morphine. She stated she did not notify law enforcement or APS because she wasn't instructed to by the Administrator. The SW stated the Director of Nursing (DON) and Administrator were also involved in the investigation and she only completed the reports and faxed them to DHSR.<br><br>A telephone interview with the former DON on [DATE] at 4:37 PM revealed she completed interviews with nurses working on Resident #223's hall when the liquid Morphine was noted to be clear in color instead of blue and sent the Morphine back to the pharmacy. She stated that was all she could recall regarding the allegation and the SW and Administrator would probably have more information.<br><br>An interview with the Administrator on [DATE] at 2:04 PM revealed the SW completed the 24-hour report and the department involved with the allegation completed the 5-day investigation. He stated once the information was collected for the 24-hour/5-day reports, he reviewed the information and consulted with the former Compliance Officer to see if any additional actions should be taken, and if not the report was sent to DHSR. The Administrator stated the former Compliance Officer did not instruct him to notify law enforcement or APS.<br><br>(continued on next page) |

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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | c. Review of the initial allegation report submitted by the facility to Division of Health Service Regulation (DHSR) via fax transmission on [DATE] at 4:48 PM noted an allegation type of resident abuse that the facility was made aware of on [DATE] at 8:30 AM. Nurse #3 alleged that Nurse #4 was unable to focus when caring for Resident #222 the night of [DATE], went to his car for long periods of time and was sleepy when he returned, drew up liquid Morphine for Resident #222 and placed the syringe behind his ear and had to be told to administer the medication, and gave the liquid Morphine too rapidly, causing the resident to get strangled. Law enforcement was not notified of the allegation.<br><br>Review of the 5-day investigative report submitted by the facility to DHSR via fax transmission on [DATE] at 12:33 PM noted Adult Protective Services (APS) was not notified of the allegation on [DATE]. Further review revealed the allegation of resident abuse was unsubstantiated.<br><br>Nurse #3 and Nurse #4 were unavailable for interview during the investigation.<br><br>An interview with the Social Worker (SW) on [DATE] at 3:02 PM revealed she was unsure if the allegation for Resident #222 needed to be reported to DHSR and did not complete the 24-hour/5-day report until she was instructed to by the Administrator. She further stated she did not notify law enforcement or APS because she wasn't instructed to by the Administrator. The SW stated the Director of Nursing (DON) and Administrator were also involved in the investigation and she only completed the reports and faxed them to DHSR.<br><br>A telephone interview with the former DON on [DATE] at 4:37 PM revealed she could not recall any further details about the allegation of resident neglect for Resident #222 and the SW and Administrator would have more information about the allegation.<br><br>An interview with the Administrator on [DATE] at 2:04 PM revealed he was unsure why Nurse #3 waited so long to report the allegation of abuse for Resident #222 since she had received education multiple times on immediately reporting abuse or neglect concerns to him or the SW. He was unable to explain why the initial report was not submitted within the 2-hour time frame. The Administrator explained the SW completed the 24-hour report and the department involved with the allegation completed the 5-day investigation. He stated once the information was collected for the 24-hour/5-day reports, he reviewed the information and consulted with the former Compliance Officer to see if any additional actions should be taken, and if not the report was sent to DHSR. The Administrator stated the former Compliance Officer did not instruct him to notify law enforcement or APS. |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51464<br><br>Based on observation and record review, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of oxygen use for 1 of 3 residents reviewed for respiratory care (Resident #272).<br><br>The findings included:<br><br>Resident #272 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease and chronic respiratory failure with hypoxia (a condition in which there is an inadequate supply of oxygen to the body's tissues).<br><br>A review of Resident #272's physician orders revealed an order dated 04/13/25 for oxygen to be administered continuously via nasal cannula at 3 liters per minute, may titrate to keep oxygen (O2) saturation greater than 90%.<br><br>A review of the admission Minimum Data Set, dated dated dated [DATE] revealed Resident #272 was not coded for oxygen use.<br><br>An observation on 04/14/25 at 11:56 AM revealed Resident #272 sitting in his wheelchair by his bed with oxygen being administered via nasal cannula by an oxygen concentrator. |

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| | 345193 | A. Building<br>B. Wing | 04/17/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Mountain View Manor Nursing Ce | 410 Buckner Branch Road<br>Bryson City, NC 28713 |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51464<br><br>Based on record review and staff interviews, the facility failed to develop a baseline care plan within 48 hours of a resident's admission (Resident #272) and ensure a baseline care plan addressed insulin use for a resident with diabetes (Resident #73) for 2 of 4 residents reviewed for respiratory care and self-administration of medications.<br><br>The findings included:<br><br>1. Resident #272 was admitted to the facility on [DATE] with diagnoses that included chronic respiratory failure with hypoxia (a condition in which there is an inadequate supply of oxygen to the body's tissues).<br><br>A review of Resident #272's medical record revealed no baseline care plan had been developed for him within 48 hours of admission.<br><br>On 04/17/25 at 9:16 AM an interview with the Admission/Discharge Nurse revealed she was responsible for completing baseline care plans, but if a resident was admitted over the weekend the nurse on the hall admitting the resident was responsible for completing it.<br><br>An interview on 04/17/25 at 10:14 AM with the MDS Coordinator revealed the nurse on the hall who admitted a resident was responsible for completing the baseline care plan. An observation of Resident # 272's electronic medical record with the MDS Coordinator showed no baseline care plan.<br><br>An interview on 04/17/25 at 12:32 PM with the Director of Nursing (DON) revealed the facility computers were not working over the past weekend as the facility had been acquired by another company and the computers were being changed over. She indicated the admitting nurse was responsible for completing the baseline care plan, and that it was important for a baseline care plan to be completed for resident care needs and preferences to be known.<br><br>On 04/17/25 at 3:38 PM an interview with the Administrator revealed baseline care plans should be completed timely and accurately by the admitting nurse.<br><br>39037<br><br>2. Resident #73 was admitted to the facility 04/07/25 with a diagnosis including diabetes.<br><br>Review of Resident #73's Physician orders revealed orders dated 04/07/25 for Insulin Glargine 100 units per milliliter inject 30 units subcutaneously (under the skin) at bedtime and Insulin Lispro 100 units per milliliter per sliding scale before meals and at bedtime.<br><br>A review of Resident #73's baseline care plan dated 04/08/25 revealed in the Medications/Treatments there was no indication she received Insulin and in the Medical Conditions section there was no indication she had a diagnosis of diabetes.<br><br>(continued on next page) |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed it was in progress.<br><br>In an interview with the Admission/Discharge Nurse on 04/17/25 at 9:15 AM she confirmed she completed Resident #73's baseline care plan. She stated Resident #73's baseline care plan should have reflected that she had a diagnosis of diabetes and received Insulin, and it was overlooked.<br><br>An interview with the Director of Nursing (DON) on 04/17/25 at 2:02 PM revealed she expected a baseline care plan to accurately reflect a resident's diagnosis and medications. She stated Resident #73's baseline care plan should have reflected she was a diabetic and received Insulin and, the person completing the baseline care plan was responsible for ensuring it was accurate.<br><br>An interview with the Administrator on 04/17/25 at 3:32 PM revealed he expected baseline care plans to be accurate. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37014<br><br>Based on observations, record review, and resident and staff interviews, the facility failed to provide showers as scheduled to a resident dependent on staff assistance for bathing for 1 of 4 residents reviewed for activities of daily living (Resident #2).<br><br>Findings included:<br><br>Resident #2 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (trouble breathing), heart failure, and anxiety disorder.<br><br>The quarterly Minimum Data Set (MDS) dated [DATE] assessed Resident #2 with intact cognition and was dependent on staff assistance with showering/bathing and transfers. She displayed no behaviors and did not reject care during the MDS assessment period.<br><br>A review of Resident #2's comprehensive care plans last reviewed/revised on 03/13/25 revealed she had an activities of daily living self-care performance deficit related to deconditioning, COPD and heart failure. Interventions included dependence on staff with showering twice weekly and as necessary.<br><br>Review of the master shower schedule revealed Resident #2 was scheduled to receive a shower on Wednesday and Saturday during the hours of 7:00 AM to 3:00 PM.<br><br>Review of the Nurse Aide (NA) point of care documentation report for April 2025 revealed no evidence Resident #2 received her showers on Saturday as scheduled.<br><br>During an observation and interview on 04/14/25 at 3:45 PM, Resident #2 was lying in bed with the head of bed slightly elevated. Resident #2's hair was uncombed and appeared greasy. Resident #2 stated she was supposed to receive two showers per week on Wednesday and Saturday but for the past 3 weeks she had not been receiving her scheduled shower on Saturday. Resident #2 could not recall the name of the staff she spoke with but stated when she asked if she was going to get her shower, their response was we'll see. Resident #2 revealed staff did not offer to give her a bed bath when a shower wasn't given nor was her hair washed until she received her scheduled shower on Wednesday. Resident #2 expressed when she didn't get a shower, she felt like she smelled and it made her feel nasty.<br><br>During an interview on 04/17/25 at 10:41 AM, Nurse Aide (NA) #3 revealed she was routinely assigned to provide Resident #2's care. NA #3 stated Resident #2 was scheduled to receive showers on Wednesday and Saturday each week and had mentioned to her in the past that she did not always receive her scheduled shower on Saturdays. NA #3 explained she frequently provided Resident #2 her scheduled shower on Wednesdays and she never refused when offered.<br><br>NA #4 who provided Resident #2's care on 04/05/25 (Saturday) and NA #5 who provided Resident #2's care on 04/12/25 (Saturday) were unable to be reached for an interview.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 04/17/25 at 11:09 AM, the Administrator in Training (AIT) revealed she was also a NA and had provided Resident #2 with a shower in the past. The AIT could not recall the date but stated it was one weekend when she was at the facility, Resident #2 had stated she didn't get her scheduled shower that Saturday. The AIT stated she reviewed the NA point of care documentation for April 2025 and confirmed there was no documentation to indicate Resident #2 was provided her showers on Saturdays as scheduled.<br><br>During an interview on 04/17/25 at 3:22 PM, the Administrator stated he would expect for staff to provided residents their showers as scheduled. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51464<br><br>Based on observations, record review, and staff interviews, the facility failed to post cautionary and safety signage outside a resident's room that indicated the use of oxygen for 1 of 3 residents reviewed for respiratory care (Resident #272).<br><br>The findings included:<br><br>Resident #272 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease and chronic respiratory failure with hypoxia (a condition in which there is an inadequate supply of oxygen to the body's tissues).<br><br>A review of Resident #272's physician orders revealed an order dated 04/13/25 for oxygen to be administered continuously via nasal cannula at 3 liters per minute, may titrate to keep oxygen (O2) saturation greater than 90%.<br><br>A review of the admission Minimum Data Set (MDS) dated [DATE] indicated Resident #272 exhibited no behavior or rejection of care and was not coded for oxygen use.<br><br>An observation on 04/14/25 at 11:56 AM revealed Resident #272 sitting in his wheelchair by his bed with oxygen being administered via nasal cannula by an oxygen concentrator. There was no cautionary or safety signage posted outside his room indicating supplemental oxygen was in use.<br><br>An observation on 04/15/25 9:22 AM revealed Resident #272 lying in bed with oxygen being administered via nasal cannula by an oxygen concentrator. There was no cautionary or safety signage posted outside his room indicating supplemental oxygen was in use.<br><br>An interview with Nurse #1 on 04/16/25 at 3:19 PM revealed the nurse assigned to the hallway was responsible for placing the oxygen in use signage but she was not aware where the signage was kept.<br><br>On 04/16/25 at 2:12 PM an interview was held with the Director of Nursing (DON). She indicated the nurse who admitted a new resident was responsible for placing the oxygen signage on the resident's door, but any nurse could place the signage. The DON continued to voice the oxygen in use signage should have been placed on Resident #272's door and was not certain why it was not in place.<br><br>An interview with the Administrator on 04/17/25 at 3:38 PM revealed the signage should have been placed on the resident's door and he did not know why it was not in place. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39037<br><br>Based on observations, record review, and staff interviews, the facility failed to secure medications stored at the bedside for 1 of 1 resident reviewed for medication storage (Resident #73).<br><br>Findings included:<br><br>Resident #73 was admitted to the facility 04/07/25 with a diagnosis including costochondritis (inflammation of the cartilage that connects a rib to the breastbone).<br><br>Review of the baseline care plan dated 04/08/25 revealed Resident #73 was cognitively intact.<br><br>Review of the medical record revealed Resident #73 was assessed for self-administration of medication on 04/08/25. The assessment indicated Resident #73 was not approved for self-administration of medications and may not keep medications at the bedside.<br><br>Review of Resident #73's Physician orders revealed an order dated 04/09/25 for Diclofenac Sodium gel 1% (anti-inflammatory medication) apply to left chest wall twice a day for 14 days.<br><br>Resident #73's admission Minimum Data Set (MDS) assessment dated [DATE] was in progress.<br><br>An observation of Resident #73's room on 04/16/25 at 8:08 AM revealed a tube of Hydrocortisone (anti-inflammatory) cream 1% sitting on top of her overbed table and a medication cup containing a whitish gel-like substance sitting on the dresser beside her bed.<br><br>An interview with Resident #73 on 04/16/25 at 8:08 AM revealed the substance in the medication cup was medication provided by the facility that she applied daily to her chest for pain. She stated she was not aware of the name of the substance in the medication cup. Resident #73 further stated her family brought her the Hydrocortisone cream for itchy skin and she applied it when she needed it. She stated she could not recall when she last applied the Hydrocortisone cream.<br><br>An interview with the Director of Nursing (DON) on 04/16/25 at 8:17 AM revealed she was unable to identify the whitish substance in the medication cup but stated it should not be left in Resident #73's room.<br><br>An interview with Nurse #1 on 04/16/25 at 3:42 PM revealed she was caring for Resident #73 on the 7:00 AM to 7:00 PM shift. She stated she didn't leave the medication cup with the whitish substance on Resident #73's dresser and if she had seen the cup she would have removed it.<br><br>An observation of Resident #73's overbed table on 04/17/25 at 8:32 AM revealed a tube of Hydrocortisone cream 1% sitting on top of the table.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A follow-up interview with the DON on 04/17/25 at 2:02 PM revealed the whitish substance in the medication cup on 04/16/25 was most likely Diclofenac Sodium. She stated no medications should be left in a resident's room unless they had been assessed as safe to self-administer the medication and if the resident was not safe to administer their medication, the medication should be stored in the medication or treatment cart.<br><br>An interview with Nurse #5 on 04/17/25 at 3:32 PM revealed she was caring for Resident #73 on the 7:00 AM to 3:00 PM shift. She stated she did not see the Hydrocortisone cream on Resident #73's overbed table and if she had she would have removed it from the room.<br><br>An interview with the Administrator on 04/17/25 at 3:19 PM revealed he expected staff to store medications appropriately. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39037<br><br>Based on observations and staff interviews, the facility failed to discard expired food from 1 of 1 walk-in cooler, date food items in 1 of 1 walk-in freezer, cover food items in 1 of 1 walk-in cooler, and remove expired food available for use from 1 of 1 dry storage room. This deficient practice had the potential to affect food served to residents.<br><br>Findings included:<br><br>1. An initial observation of the walk-in cooler on [DATE] at 10:02 AM revealed a box of thawed premade peanut butter and honey sandwiches with a date of [DATE].<br><br>An interview with the Dietary Manager on [DATE] at 10:05 AM revealed the date of [DATE] indicated that was the date the sandwiches were placed in the cooler, and she was not sure how long they were good for after they were thawed but she would check.<br><br>A follow-up interview with the Dietary Manager on [DATE] at 11:00 AM revealed she was unable to locate the manufacturer's information on how long the premade sandwiches were good for after being thawed, so she discarded the sandwiches.<br><br>An interview with the Administrator on [DATE] at 3:13 PM revealed he expected food to be stored according to manufacturer's guidelines.<br><br>2. An initial observation of the walk-in freezer on [DATE] at 10:07 AM revealed 2 undated bags of french toast sitting on a shelf in the freezer and a box of frozen pizzas open to air.<br><br>An interview with the Dietary Manager on [DATE] at 10:10 AM revealed the french toast should have had a date written on it when it was placed in the freezer by the staff member. She stated the pizzas should have been covered and not left open to air by the staff member who opened the box.<br><br>An interview with the Administrator on [DATE] at 3:13 PM revealed he expected all food in the walk-in freezer to be dated and covered appropriately.<br><br>3. An initial observation of the dry storage room on [DATE] at 10:15 AM revealed two and a half cases of canned pureed turkey sitting on a shelf with a best-by date of [DATE].<br><br>An interview with the Dietary Manager on [DATE] at 10:18 AM revealed the turkey should have been used or discarded on or before the best-by date.<br><br>An interview with the Administrator on [DATE] at 3:13 PM revealed he expected food to be used or discarded on or before the best-by date. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>47683<br><br>Based on observations, record review, staff interviews, and review of the facility's policies and procedures, the facility staff failed to follow infection control procedures when Nurse #1 did not don a gown while administering Resident #51's tube feeding for 1 of 5 staff members observed for infection control practices.<br><br>The findings included:<br><br>Review of the facility's undated policy for Enhanced Barrier Precautions revealed that gowns and gloves should be worn when performing high contact resident care activities such as device care or use with central lines, urinary catheters, feeding tubes, tracheostomies or ventilators.<br><br>An observation on 04/16/25 at 11:59 AM of Nurse #1 entering Resident #51's room that had a sign on the door for Enhanced Barrier Precautions which instructed staff to don gloves and gown. Nurse #1 entered the room and informed Resident #51 she was going administer his tube feed, washed her hands, and applied clean gloves. Nurse #1 proceeded to attach the tube extension set to the gastrostomy tube (feeding tube surgically inserted into the stomach) and administered the bolus tube feeding.<br><br>An interview with Nurse #1 on 04/16/25 12:01 PM revealed that she did not need to put on a gown for the administration of a tube feed. She stated that she thought the sign was for Resident #51's roommate and that she wasn't sure.<br><br>A phone interview on 04/16/25 at 1:05 PM with the Infection Preventionist revealed that the Enhanced Barrier Precaution sign was for Resident #51. She stated that Nurse #1 should have worn gown and gloves for the administration of the tube feeding. She stated that Nurse #1 had been educated on what Enhanced Barrier Precautions were and when they needed to be implemented. She stated that if a staff member was unsure who was on Enhanced Barrier Precautions there was an A or B on the sign on the door or on the back of the door indicating which bed was on precautions. She further stated that there was a list posted at the nurse's station letting staff know which residents were on precautions.<br><br>A joint interview on 04/16/25 at 12:24 PM with the Administrator and the Administrator in Training (AIT) revealed Enhanced Barrier Precautions were for Resident #51 because of his feeding tube. The AIT stated that during education it was explained that if staff entered a room to provide care in a room that had Enhanced Barrier Precautions sign, and the staff were unsure which resident the signs were for then the staff should assume it applied to both residents and put on the appropriate personal protective equipment (PPE). The Administrator stated that his expectations were that if Enhanced Barrier Precaution signage was present that staff put on the appropriate PPE when providing direct patient care. |