STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345432	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Bend Health and Rehabilitation	213 Richmond Hill Drive Asheville, NC 28806

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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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37014 Based on record review, family and staff interviews, the facility failed to invite residents and/or their Resident Representative (RR) to participate and provide input in care planning for 1 of 2 sampled residents (Resident #30). This practice had the potential to affect other residents. Findings included: Resident #30 admitted to the facility on [DATE] with multiple diagnoses that included hemiplegia (paralysis on one side of the body) and hemiparesis (partial weakness on one side of the body) following cerebral infarction (stroke) affecting the left non-dominant side and dementia. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #30 had severe cognitive impairment. Review of Resident #30's electronic medical record revealed an admission MDS assessment was completed on 12/05/23 and quarterly MDS assessments were completed on 03/04/24 and 06/04/24. Further review revealed no evidence that she or her RR were invited to attend a care plan meeting to discuss and provide input regarding her plan of care following the completion of the admission and quarterly MDS assessments. During an interview on 06/23/24 at 12:27 PM, Resident #30's RR revealed he was unaware of the facility's process regarding conducting care plan meetings. The RR recalled attending a care plan meeting with staff when Resident #30 was first admitted to the facility but there had been no care plan meetings held since. During an interview on 06/26/24 at 10:49 AM, the Social Worker (SW) revealed the MDS Nurse used to keep track of the care plan meeting schedule but when the new corporation took over in September 2023, the responsibility for keeping track of the care plan schedules, sending out invitations and facilitating the meetings was placed back on him. He stated during the transition, the process kind of fell through and some care plan meetings were missed as a result. The SW explained he had been working on improving the process by looking at when care plan meetings were due and sending out invitations the month prior so that care plan meetings were scheduled on time. The SW confirmed Resident #30 did not have any care plan meetings held and he was currently working on getting one scheduled. (continued on next page)

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

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/26/24 at 1:39 PM, the Regional Clinical Nurse Consultant confirmed a care plan meeting was not conducted with Resident #30 or her RR. The Regional Clinical Nurse Consultant explained when the issue with care plan meetings not being conducted was first identified, the SW had made a pretty good attempt at completing a Performance Improvement Plan (PIP); however, they did not currently have a sufficient PIP in place. During a joint interview on 06/27/24 at 6:12 PM, the Regional Clinical Nurse Consultant and Administrator both stated care plan meetings should be conducted on a routine basis and they both felt the breakdown in the process was due to the lack of knowledge on who was responsible for scheduling and keeping track of when care plan meetings were due.

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36217 Based on observation and staff interviews, the facility failed to protect the private health information for 2 of 2 sampled residents (Resident #1 and Resident #53) by leaving confidential medical information unattended and exposed in an area accessible to the public. The findings included: Resident #1 was admitted to the facility on [DATE]. a. A continuous observation was made on 06/25/24 from 9:31 AM through 9:36 AM of an unattended medication cart in the hallway of Lower C halls between room C09 and C11. Nurse #1 left the medication cart with the Medication Administration Record (MAR) of Resident #1 visible on the medication cart's computer screen when she was away administering medication. The screen showed the name and the picture of Resident #1. The surveyor could easily access information related to her current medications and other private health information. The unattended computer was accessible by anyone passing by the medication cart. During an interview with Nurse #1 on 06/25/24 at 9:39 AM, she explained she was distracted by a resident when retrieving medication for Resident #1 and had forgotten to turn on the privacy protection screen before leaving the medication cart. She stated it was an oversight and acknowledged that it was inappropriate to leave residents' private health information unattended. She indicated that she had completed the Health Insurance Portability and Accountability Act (HIPAA) training provided by the facility a few months ago. b. Resident #53 was admitted to the facility on [DATE]. On 06/25/24 at 1:10 PM, as the surveyor passed by Nurse #1's medication cart parked outside of the nurse station by Lower C halls, the computer screen was again left unattended and showing Resident #53's MAR. The screen was readily observable or accessible by anyone who was not authorized to view this private health information. Nurse #1 was seen talking to a staff member in the office approximately 10 feet away from the medication cart and returned to the medication cart in about 2 minutes. In an interview conducted on 06/25/24 at 1:12 PM, Nurse #1 apologized for failing to safeguard residents' personal health information repeatedly. She explained she had a lot of things going on in her halls and she was badly distracted. During an interview conducted on 06/26/24 at 1:14 PM, the Acting Director of Nursing (DON) expected all the nurses to turn on the privacy protection screen before leaving the medication cart to ensure all the confidential personal and medical information were protected. It was her expectation for all the staff to follow the HIPAA guidelines when working in the facility. An interview was conducted with the Administrator on 06/26/24 at 1:54 PM. He stated the facility provided HIPAA training for all the staff during orientation and subsequent training at least once a year. It was his expectation for all the staff to safeguard residents' personal health information all the time.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37014 Based on record review and staff interviews, the facility failed to identify and implement effective interventions to prevent resident-to-resident physical abuse when a severely cognitively impaired resident (Resident #23) with a known history of aggression hit another severely cognitively impaired resident (Resident #11) in the face for 1 of 5 residents reviewed for abuse. As a result of the incident, Resident #11 sustained a small cut measuring 0.2 centimeters (cm) by 0.1 cm to the left eyebrow and bruising to the left top of hand measuring 3.5 cm by 3 cm. Findings included: Resident #11 was admitted to the facility on [DATE] with diagnoses that included hemiplegia (complete paralysis on one side of the body) and hemiparesis (partial weakness on one side of the body) following cerebral infarction (stroke) affecting the left non-dominant side, diabetes, vascular dementia, psychotic disturbance, and anxiety. The quarterly Minimum Data Set (MDS) assessment dated [DATE] assessed Resident #11 with severe cognitive impairment. He required supervision or touching assistance with wheeling in a manual wheelchair and displayed physical behaviors directed toward others 1 to 3 days during the MDS assessment period. A care plan last reviewed/revised on 12/26/23 revealed in part Resident #11 had a behavior problem related to hitting, kicking staff, yelling, cursing and was not easily redirected. Interventions included for staff to administer medications as ordered, explain/reinforce why his behavior was inappropriate or unacceptable, intervene as necessary to protect the rights and safety of others and remove him from the situation and take him to an alternate location as needed. Resident #11 was unable to be interviewed due to cognition. A hospital history and physical progress note dated 03/15/24 revealed in part, On 03/13/24, [Resident #23] was brought to the Emergency Department (ED) due to increased agitation and aggression at his group home facility, leading to an involuntary psychiatric hold and necessitating long-term placement at another facility. A hospital psychiatric consult note dated 03/18/24 revealed in part, Resident #23 has a past psychiatric history of major neurocognitive disorder secondary to traumatic brain injury (TBI) sustained in 2011 with behavioral disturbance, seizure disorder, impulse control disorder, and mood disorder due to general medical condition (TBI). He initially present to the ED with altered mental status, was admitted to hospitalist service, and psychiatry consulted for aid in managing aggression. Presents with disorientation, poor attention and impaired memory as well was chronic major neurocognitive disorder secondary to TBI. He is known to suffer chronic aggression and mood lability [refers to something that can change quickly or spontaneously] secondary to this diagnosis. His condition is not modifiable by admission to acute inpatient psychiatric unit and therefore, he does not meet criteria for involuntary commitment. Recommend pursing placement. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #23 was admitted to the facility on [DATE] with diagnoses that included diffuse traumatic brain injury (TBI) with loss of consciousness of unspecified duration, bipolar disorder, and impulse disorder. A care plan initiated on 03/23/24 revealed Resident #23 had the potential to be verbally aggressive related to TBI, depression and neurocognitive disorder with impulse control disorder. Interventions included to administer medications as ordered, analyze and document key times, places circumstances, triggers and what de-escalates the behavior. The admission MDS assessment dated [DATE] assessed Resident #23 with severe impairment in cognition. He required supervision or touching assistance with wheeling in a manual wheelchair and displayed no behaviors during the MDS assessment period. A nurse progress note dated 05/25/24 at 6:33 PM and written by Nurse #8 revealed, Resident #23 hit Resident #11 for entering his room. Resident #23 struck Resident #11 multiple times with both fists and shoved Resident #11 twice in the wheelchair. Resident #23 stopped hitting Resident #11 once staff was headed towards them. A visitor from across the hall witnessed the situation from beginning to end. Review of the investigation report dated 05/25/24 revealed an allegation/incident type of Resident Abuse that occurred on 05/25/24 at 6:00 PM and noted Resident #23 hit Resident #11 causing a small skin tear. Law enforcement and the Department of Social Services (DSS) were both notified and the facility substantiated the allegation. Review of the facility's investigation file revealed an undated and unsigned typed summary of the investigation that revealed on 05/25/24 at approximately 6;50 PM a visitor notified nursing staff that they had witnessed Resident #23 hitting Resident #11 who was trying to defend himself. Resident #23 was removed from the area and placed on increased staff supervision. When asked by staff why he hit Resident #11, Resident #23 stated he was sitting in my door and wouldn't move and I hit him. Both residents were assessed for injuries and Resident #11 sustained a small cut to the left eyebrow and bruising to his left hand. Nurse #2 immediately notified the Administrator of the incident. On 05/28/24, when the Administrator spoke with both Resident #11 and Resident #23, neither resident recalled the incident from 05/25/24. There been no further incidents between Resident #23 and Resident #11 since 05/25/2. It was noted that the facility substantiated the allegation of resident-to-resident abuse because it was a witnessed incident. Continued review of the facility's investigation file revealed an undated statement written by Nurse #2 that revealed Nurse #8 reported a visitor had informed staff that they had witnessed Resident #23 hitting Resident #11. Upon nursing assessment, Resident #23 had no injuries and Resident #11 had a small cut above the left eyebrow measuring 0.2 cm x 0.1 cm and a large area of bruising to the left hand measuring 3. 5 cm x 3 cm. Staff stated Resident #23 was the one who was hitting Resident #11 who had his hands up trying to protect himself but when they reached the residents, they were not fighting. Nurse #2 spoke with Resident #23 and explained to him that he should call for staff assistance as it was never appropriate to hit or strike at other people. Nurse #2 noted that Resident #23 had agreed but was upset that Resident #11 was blocking the door. Nurse #2 also noted that she was unable to interview the visitor who witnessed the incident because they had already left the facility. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 06/27/24 at 10:47 AM, Nurse #8 revealed on 05/25/24, a visitor (she could not recall their name) notified her that when Resident #11 had gone into Resident #23's room, Resident #23 shoved Resident #11 backwards in his wheelchair and started punching him. Nurse #8 stated she did not witness the incident but did assess Resident #11 and he had a cut above his eye. Nurse #8 stated both residents were immediately separated and Resident #23 was placed on staff supervision. Nurse #8 did not recall Resident #23 displaying any increased aggression that evening prior to him hitting Resident #11. Nurse #8 stated Resident #23 was not on the ground floor long (where the incident with Resident #11 occurred) as he was moved to a room on the first floor shortly after the incident. An unsuccessful telephone attempt for an interview with Nurse #2 was made on 06/27/24 at 12:05 PM. During a joint interview on 06/27/24 at 6:12 PM with the Regional Clinical Nurse Consultant present, the Administrator revealed they were aware of Resident #23's history of aggressive behaviors when he was admitted to the facility on [DATE]; however, he was not aware of any specific interventions or increased supervision that were put into place at the time of Resident #23's admission to the facility. The Administrator stated he was notified of the incident by staff on 05/25/24 and the residents were separated. He stated they did substantiate the resident-to-resident abuse because it was witnessed; however, they were unable to determine any real precursor that led Resident #23 to hit Resident #11. The Administrator verfied that following the incident with Resident #11 on 05/25/24, Resident #23 had not had any further incidents with other residents but he had struck a staff member, was sent out to the hospital for a psychiatric evaluation and upon his return to the facility, Resident #23 was placed one-to-one staff supervision that would likely be indefinite.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36217 Based on record review and interviews with resident, staff, and the Nurse Practitioner (NP), the facility failed to protect residents' rights to be free from misappropriation of controlled medications for 3 of 3 residents (Resident #29, Resident # 58, and Resident #113) reviewed for misappropriation of residents' property. The findings included: The facility's Abuse, Neglect, or Misappropriation of Resident property policy, last revised on [DATE], revealed in part the facility would ensure all residents to remain free from abuse or misappropriation of their property. a. Resident #29 was admitted to the facility on [DATE] with diagnoses including acute respiratory distress. A review of the physician's order dated [DATE] revealed Resident #29 had an order to receive 0.25 milliliters (ml) of morphine sulfate oral solution with the strength of 20 milligrams (mg) per ml by mouth once every 4 hours as needed for pain related to acute respiratory distress. A review of the controlled substance count sheet for Resident #29's liquid morphine sulfate revealed it had 25 ml remained in the medication cart after it was last administered on [DATE]. The quarterly Minimum Data Set (MDS) dated [DATE] coded Resident #29 with a severely impaired cognition. A review of the medication administration records (MARs) for February 2024 revealed Resident #29 had received only 1 dose of liquid morphine sulfate in February on [DATE]. The initial allegation report dated [DATE] revealed the facility became aware of the misappropriation of Resident #29's property on [DATE] at 8:00 PM when the Administrator and Director of Nursing (DON) were notified that Nurse #6 was noted with a change in behavior on duty and later removed from providing resident care. The in-house drug screening confirmed Nurse #6 tested positive for morphine. The local sheriff's office was notified, and Resident #29 was assessed immediately without any adverse consequences noted as she had not utilized the as needed medication since [DATE]. The missing medication was replaced at facility cost. Investigation was initiated by DON immediately. The 5-day investigation report dated [DATE] revealed the allegation of misappropriation of residents' property was substantiated based on record review, observation, and interviews. Nurse #6 had a change in mentation and behavior after he started his shift on [DATE]. He tested positive for morphine when Resident #29 had a bottle of the same medication missing according to narcotic count sheets reconciliation. The police report confirmed Nurse #6 had possession of controlled medication in his apartment with Resident #29 and facility's name on the label. All the medication carts were counted again on [DATE] with no further discrepancies noted. The North Carolina Board of Nursing (NCBON) was notified for further investigation. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with Nurse #1 on [DATE] at 4:20 PM. She stated she was the Unit Manager (UM) of Lower halls for the 7 PM to 7 AM shift on [DATE] evening. When Nurse #6 assumed the medication cart from the outgoing nurse, the controlled substance counts were without discrepancies. At around 8:30 PM, she saw Nurse #6 talking to nobody in the hallway. When she approached him, his eyes were red as if he was crying. Nurse #6 told her that someone was trying to take away his job and he might as well kill himself. This was a red flag for Nurse #1 due to Nurse #6's erratic behavior and she texted the former DON #1 immediately. Former DON #1 replied she would return to the facility. When the former DON #1 arrived, she had a closed-door conversation with Nurse #6. Immediately after the conversation, the former DON #1 ordered Nurse #6's to surrender the medication cart key. Then, the former DON #1 instructed her and another nursing staff to count Nurse #6's medication cart. They found that a bottle of approximately 25 ml of liquid morphine sulfate for Resident #29 was missing. The former DON #1 ordered Nurse #6 to have a drug screening. Nurse #6 complied and was later tested positive for morphine. During an interview conducted on [DATE] at 1:03 PM, the Staffing Coordinator recalled former DON #1 called her on [DATE] in the evening to assist in a drug diversion incident. When she arrived at the Lower halls, she saw Nurse #6 had a bottle of liquid in his pocket as it could be seen from the outline of his clothing. The former DON #1 requested Nurse #6 to have a drug screening and he complied. The urine specimen tested positive for morphine. During an interview conducted on [DATE] at 4:34 PM, Resident #29 stated she could not recall anything related to the drug diversion in February and added she did not suffer any pain at that time. An attempt to interview Nurse #6 on [DATE] at 10:47 AM was unsuccessful. He did not return the call. During a phone interview conducted on [DATE] at 10:51 AM, former DON #1 stated when she arrived at the facility on [DATE] in the evening, Nurse #6 appeared impaired and could hardly recognize her. His eyes were red, half open, and a bottle was seen in his pocket. As she confirmed Nurse #6 was unfit to continue his duty as a nurse, she requested him to relieve the medication cart key. She immediately counted the medication cart with the help of 2 nursing staff and found that a bottle of liquid morphine sulfate contained 25 ml for Resident #29 was missing. She called the police immediately and requested Nurse #6 to provide urine specimen for a drug screening, and he complied. Then she took Nurse #6 to the office and asked him what he had taken in the past 24 hours. Nurse #6 stated he had taken marijuana and oxycodone the night before and some Ativan before leaving his apartment. She wanted Nurse #6 to go home and offered to transport him to the hospital if needed. The drug screening results that came out about 15 minutes later confirmed Nurse #6 was positive for morphine. When she told Nurse #6 that she had to report the incident to NCBON, he became angry and left the facility. The police arrived right after Nurse #6 had left the building. Later that night, she received a call from the police stating when they were responding to a medical emergency call, they found an empty bottle of liquid morphine in Nurse #6's apartment with the label indicating it belong to Resident #29 in the facility. She reported the incident to the North Carolina Department of Health & Human Services (NC DHHS), NCBON, Resident #29's Responsible Party, and the Medical Director immediately. Resident #29 was assessed immediately without any adverse consequences noted as the liquid morphine was used as needed basis, and she did not request it when the incident happened. She added all the missing medications were replaced and paid for by the facility later. She instructed nursing staff to assess all other residents to ensure they were not affected by the incident. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Resident #58 was admitted to the facility on [DATE] with diagnoses including right tibia fracture. A review of the physician's order dated [DATE] revealed Resident #58 had an order to receive 5 mg of oxycodone by mouth once every 8 hours as needed for moderate to severe pain. The quarterly MDS dated [DATE] coded Resident #58 with an intact cognition. A review of the controlled substance count sheet for Resident #58's oxycodone revealed Nurse #3 had signed out one tablet of oxycodone 5 mg for Resident #58 on [DATE] at 9:30 AM. Further review of the signatures on the controlled substance count sheets revealed it was very different from the signatures Nurse #3 documented on other narcotic count sheets. A review of the MARs for [DATE] revealed Nurse #3 had signed out 1 tablet of oxycodone 5 mg for Resident #58 on [DATE] at 3:37 PM with pain level of 7 out of 10 scale. Resident #58 received 1 tablet of oxycodone 5 mg earlier that day at 3:62 AM. Resident #113 was admitted to the facility on [DATE] with diagnoses including thrombocytopenia. He passed away in the facility on [DATE]. A review of the physician's order dated [DATE] revealed Resident #113 had an order to receive 5 mg of oxycodone by mouth once every 12 hours for moderate to severe pain. This order was discontinued on [DATE]. A review of the MARs for [DATE] revealed Resident #113 had received oxycodone 5 mg only once on [DATE]. The admission MDS dated [DATE] coded Resident #113 with an intact cognition. A review of the controlled substance count sheet for Resident #113's oxycodone revealed his oxycodone was signed out by different nurses three times on [DATE], one time on [DATE], and one time on [DATE]. Further review of the signatures in the controlled substance count sheet revealed they could have been written by the same person based on similarities of the ink and handwriting. The initial allegation report dated [DATE] revealed the facility became aware of the misappropriation of residents' property on [DATE] at 3:30 PM when the Administrator and the DON were notified that Nurse #7 had stolen 1 tablet of oxycodone 5 mg from Resident #58 and 5 tablets of oxycodone 5 mg from Resident #113 who had expired 12 days ago. Resident #58 had 25 tablets of oxycodone remained in the medication cart and was provided with the as needed oxycodone as ordered in a timely manner on [DATE]. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 5-day investigation report dated [DATE] revealed Nurse #7 was normal when she reported to duty on [DATE]. About 2 hours after she started her shift, she appeared to be under the influence of unknown substances. As Nurse #7 was too impaired to complete her work safely, the UM reported the incidents to the Administrator and DON and obtained an order to send her home and placed on do not return status with the agency. Nurse #3 who assumed the medication cart from Nurse #7 found that one tablet of oxycodone 5 mg for Resident #58 was signed out using her name when she did not have access to that medication cart. Resident #58 was able to attest to the fact that Nurse #3 did not give her any oxycodone that morning. Nurse #3 called both the DON and Administrator for her findings. The allegation of misappropriation of residents' property was substantiated based on empirical evidence and witness statements. The Sheriff's office was reported, and Nurse #3 was instructed to do a review of all narcotic sheets with that medication cart. She discovered Resident #113 who was deceased on [DATE] had 5 tablets of oxycodone 5 mg signed out with several different nurses' names fraudulently. The staffing agency and NCBON were notified immediately. During an interview conducted on [DATE] at 10:57 AM, Resident #58 recalled when she asked for her as needed oxycodone on [DATE] afternoon, she was told by Nurse #3 that it was too early as she already had it at 9:30 AM. Further investigation by the facility staff revealed her oxycodone was stolen by Nurse #7. The former DON #2 requested her to write a statement confirming she did not get the oxycodone from any nurse that morning. She received her oxycodone that day in a timely manner without suffering any pain. An interview was conducted with Nurse #3 on [DATE] at 3:43 PM. She stated Nurse #7 was scheduled to work on [DATE] from 7 AM through 7 PM. It was Nurse #7's first day working in the facility, and she arrived late at about 10 AM. At around noon time, a staff member from assisted living reported Nurse #7 was sleeping in a chair in the assisted living dining area. Since she was the nurse working with Nurse #7 in the Upper halls at that time, she reached out to Nurse #1 who was also the UM to discuss the situation. While they were having a discussion in the break room, Nurse #7 came in suddenly and asked if they had seen a resident who was not in the facility. Nurse #7 appeared to be under influence with confusion and erratic behavior at that time. She called former DON #2, but she was unavailable to answer the call. Then, the UM called the Administrator and received an order to send Nurse #7 home at approximately 2 PM. She counted the controlled medications in the medication cart with Nurse #7 before she left the halls, and it was without discrepancies. After Nurse #7 had left the halls, Resident #58 asked for her as needed oxycodone at around 3:30 PM. She found that one tablet of oxycodone 5 mg was signed out under her name at 9:30 AM that morning, when she did not have access to the medication cart at that time. The signature was faked and looked very different from her other signatures in the narcotic count sheets. In addition, Resident #58 confirmed that she did not receive oxycodone from any nurses that morning with a written statement. She reported the incident to the Administrator immediately and Nurse #1 reported the incident to the local sheriff's office and Medical Director. After identifying discrepancies in narcotic count sheets for Resident #58, she quickly checked other controlled medication count sheets in the same cart and found that Resident #113 who had passed away on [DATE], had 3 tablets of oxycodone 5 mg signed out on [DATE], 1 tablet on [DATE], and 1 tablet on [DATE] with signatures of several different nursing staff. She confirmed the signatures were faked by calling all the nursing staff whose names appeared on the narcotic count sheet. While Nurse #7 was still waiting for Uber to pick her up, the police arrived around 5 PM. Nurse #7 denied taking controlled medications from the medication cart and stated those signatures were not written by her. The police then escorted her out of the building. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview conducted on [DATE] at 4:20 PM, Nurse #1 stated she was the UM on [DATE] morning. After receiving the report of Nurse #7 sleeping in the dining room in assisted living area, she talked to Nurse #7 and found that she was disoriented and appeared to be under influences. Nurse #7 explained she was exhausted as she did not sleep the night before due to her daughter having a seizure. Then, she obtained an order from the Administrator to send Nurse #7 home. After Nurse #7 left the halls, Nurse #3 found that Nurse #7 had signed out 1 tablet of oxycodone for Resident #58 and 5 tablets of oxycodone for Resident #113 fraudulently. The Administrator ordered her to file a report to the local sheriff's office, the staffing agency, and the Medical Director. Resident #58 received her as needed oxycodone without delay or adverse consequences noted. The missing oxycodone was replaced and paid for by the facility later. An interview was conducted with NP #2 on [DATE] at 12:10 PM. She stated the Medical Director was currently on vacation. She confirmed receiving notifications of both drug diversions in February and [DATE] and was provided with the list of residents affected. The staff assessed affected residents immediately without any adverse consequences noted. She expected the facility to have a system in place and properly implemented to account for the receipt, disposition, and reconciliation of all controlled medication to prevent or deter drug diversions. During an interview conducted on [DATE] at 1:14 PM, the Acting DON recalled seeing Nurse #6 yawning while talking to her during the shift transition on [DATE]. Nurse #6 explained he did not sleep well the night before. She stated Nurse #6 looked tired but seemed to be fine at that time. She left the facility after her shift. For the second incident that occurred on [DATE], she recalled Nurse #1 who was the UM called her when she was at home, reporting Nurse #7 was disoriented, impaired, and appeared to be under influence at work. She told Nurse #1 to report the incident to former DON #2 who was the DON at that time. It was her expectation for the facility to remain free of misappropriation of property. An interview was conducted with the Administrator on [DATE] at 1:54 PM. He expected staff members to safeguard residents' personal property including medication when working in the facility. It was his expectation for the facility to remain free of misappropriation of property. An attempt to conduct a phone interview with Nurse #7 on [DATE] at 10:49 AM was unsuccessful. The phone number was no longer in service. An attempt to conduct a phone interview with former DON #2 on [DATE] at 11:01 AM was unsuccessful. She did not return the call.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37014 Based on record review and staff interviews the facility failed to implement their abuse policy and procedures in the areas of reporting and investigation by not submitting an Initial Allegation Report within 2 hours to the State Regulatory Agency and not initiating an investigation when an allegation of abuse was reported to the Administrator. This deficient practice affected 1 of 5 residents reviewed for abuse (Resident #31). Findings included: The facility's undated policy titled, Abuse, Neglect and Exploitation, read in part, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. Written procedures for investigations include: identifying staff responsible for the investigation; identifying and interviewing all persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; providing complete and thorough documentation of the investigation. The facility will have written procedures that include: reporting of all alleged violations to the Administrator, State Agency, Adult Protective Services and to all other required agencies (e.g., law enforcement when applicable within specified timeframes: a) Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse and result in serious bodily injury or b) Not later than 24 hours if the events that cause the allegation do no involve abuse and do not result in serious bodily injury; and assuring that reporters are free from retaliation or reprisal. Resident #25 was admitted to the facility on [DATE]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #25 had intact cognition. Resident #31 was admitted to the facility on [DATE]. The quarterly MDS assessment dated [DATE] revealed Resident #31 had moderate impairment in cognition. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An undated, typed statement provided by the Medical Records Director revealed in part, At 3:22 PM I received an email from the Administrator asking me to get 7 staff and 7 resident surveys completed. I asked [Resident #25] if I could ask her some questions for the survey I was doing. When I asked the question on the survey, have you witnessed or suspected any abuse against yourself or another resident she responded yes. I then asked her what she had seen. [Resident #25] then stated she witnessed a resident go after staff when they were attempting to change her. It made her very nervous and was upsetting. When asked who the resident was, she stated it was her roommate, [Resident #31], and the incident happened last night (no date indicated). [Resident #25] went on to describe how [Resident #31] fought and kicked the male staff member who told her she needed to be changed. [Resident #25] said it had gone on for some time. [Resident #25] did not know the name of the staff member and only stated the staff member was a male. [Resident #25] stated [Resident #31] screamed at the male staff member to stop and get off of her. [Resident #25] stated [Resident #31] screamed no to the male staff member several times but he never got off of her nor did he stop what he was doing. [Resident #25] stated [Resident #31] fought the male staff member hard and after [Resident #31] was changed, he left. After I left the room, I sent a text message to the Regional MDS Consultant to let her know. The Regional MDS Consultant called me and told me to reach out to the Administrator to let him know. I told the Administrator what [Resident #25] had reported to me about [Resident #31] and a male staff member. During an interview on 06/24/24 at 9:45 AM and follow-up interview on 06/26/24 at 3:12 PM, Resident #25 stated she had never observed staff be abusive toward Resident #31 or any resident. Resident #25 also stated she had never witnessed a staff member holding Resident #31 down to provide care when she repeatedly said no and did not recall reporting such an incident to anyone. During an interview on 06/24/24 at 10:06 AM and follow-up interview on 06/26/24 at 3:09 PM, Resident #31 voiced no concerns of abuse. Resident #31 stated she had never been abused in any way by staff or other residents and there had been no time when staff ever provided care to her against her wishes. During an interview on 06/24/24 at 4:56 PM and follow-up interview on 06/27/24 at 8:43 AM, the Medical Records Director revealed when she was conducting interviews on 05/29/24 with alert and oriented residents as part of a separate abuse investigation, Resident #25 reported during the night of 05/28/24 a male staff member had come into the room to provide care to her roommate, Resident #31. Resident #25 did not know the staff member's name but stated Resident #31 repeatedly told the staff member no when he kept telling her she needed to be changed and Resident #31 was being resistive toward the staff member as he held her down and continued to provide care against her will. The Medical Records Director stated she did not discuss the allegation with Resident #31 as Resident #25 had given a very vivid description of the alleged incident and she felt Resident #25 was a reliable historian. The Medical Records Director stated she immediately notified her direct supervisor, the Regional MDS Consultant, on 05/29/24 to explain what was reported to her by Resident #25 and was instructed to notify the Administrator. She stated she verbally informed the Administrator on 05/29/24 of what was alleged by Resident #25 and he was dismissive, stating that it did not count as abuse and did not need to be reported to the State Agency. The Medical Records Director stated she also sent the Administrator her typed statement of the alleged incident but never heard anything back. She stated she was unable to find the actual email where she sent her typed statement to the Administrator but was certain it was on 05/29/24 after she spoke to her supervisor, the Regional MDS Consultant. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 06/26/24 at 4:25 PM, the Regional MDS Consultant confirmed around 05/28/24 or 05/29/24 the Medical Records Director had contacted her to discuss an allegation of abuse that had been reported to her by a resident. She could not recall the actual date, names of the residents or the specific details of the allegation she discussed with the Medical Records Director. When informed of what the Medical Records Director reported in her interview of what Resident #25 alleged happened to Resident #31, the Regional MDS Consultant stated that sounded correct. The Regional MDS Consultant recalled the Medical Records Director was worried she would get into trouble, she assured her that would not be the case and then they discussed what the Medical Records Director needed to do which was to report the allegation to the Administrator. The Regional MDS Consultant stated after speaking with the Medical Records Director, she also spoke to the Administrator via telephone about the issue and he stated he would start an investigation. During an interview on 06/27/24 at 9:22 AM, the Administrator stated he did not recall any employee or the Regional MDS Consultant informing or discussing with him an allegation made by Resident #25 regarding an employee providing care to Resident #31 against her wishes. The Administrator confirmed there had been no reports submitted to the State Regulatory Agency or investigation of any such incident. During an interview on 06/27/24 at 3:03 PM, the Regional Clinical Nurse Consultant stated when she and the Administrator looked into the alleged incident, they discovered that the Medical Records Director had informed the Administrator that Resident #25 had reported an incident involving Resident #31 and a male staff member. She stated the allegation was reported during a conversation about other issues and somehow got lost in the translation. She stated they were able to determine the alleged event happened on 05/28/24, an initial report was submitted to the State Regulatory Agency today (06/27/24) and an investigation started. The Regional Clinical Nurse Consultant stated the initial report should have been submitted when the allegation was initially reported to the Administrator and it just fell through the cracks. During a follow-up interview on 06/27/24 at 6:12 PM with the Regional Clinical Nurse Consultant present, the Administrator stated after speaking with the surveyor he did recall the Medical Records Director had notified him that Resident #25 reported Resident #31 had hit a staff member and he told the Medical Records Director that it did not need to be reported to the State Regulatory Agency. The Administrator stated the details told to him at the time were not what was described in the Medical Records Director's statement and it was never indicated that care continued to be provided to Resident #31 against her wishes. He stated had that been made clear at the time, he would have immediately submitted a report to the State Regulatory Agency and started an investigation.

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F 0655 Level of Harm - Potential for minimal harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37014 Based on record review, resident and staff interviews, the facility failed to complete a baseline care plan that addressed the resident's immediate needs within 48 hours of admission and failed to provide the resident or their Responsible Party (RP) with a written summary of the baseline care plan for 2 of 7 residents reviewed for dialysis and nutrition (Resident #22 and Resident #25). The findings included: 1. Resident #22 was admitted to the facility on [DATE] with diagnoses including diabetes, end-stage renal disease and dependence on renal dialysis. The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #22 had intact cognition. He required partial/moderate to substantial/maximal assistance with self-care tasks and mobility. Further review revealed Resident #22 received dialysis services and a therapeutic diet. Review of Resident #22's medical record revealed a baseline care plan was initiated on 04/16/24 and signed as complete by the former Director of Nursing (DON) on 05/03/24. The baseline care plan did not include initial goals or interventions to address his need for dialysis services, nutrition or discharge plans. During an interview on 06/27/24 at 10:12 AM, Resident #22 stated he had discussed his discharge goals and future plans to return to the community with facility staff but was unable to recall the date. Resident #22 stated he did not recall discussing his baseline care plan with facility staff or receiving a written copy of his baseline care plan within 48 hours of his admission on 04/16/24. The former DON was no longer employed and unable to be interviewed. During an interview on 06/26/24 at 1:39 PM, the Regional Clinical Nurse Consultant explained baseline care plans were part of the nursing admission assessment and it was the responsibility of the admitting nurse to complete the baseline care plan, review it with the resident or RP and provide them with a copy. However, they discovered the baseline care plan was not automatically printing when the admission assessment was printed and the nurses had been unaware they needed to ensure the baseline care plan printed and was reviewed with the resident or their RP. During a joint interview on 06/27/24 at 6:12 PM, both the Regional Clinical Nurse Consultant and Administrator stated it was the responsibility of the admitting nurse to complete and review the baseline care plan with the resident or their RP within 48 hours of admission. They both stated they felt the breakdown was due to nurses being unaware to print the baseline care plan and having a copy signed once reviewed with the resident or RP. 37538 2. Resident #25 was admitted to the facility on [DATE] with diagnoses including diabetes mellitus and severe protein-calorie malnutrition. (continued on next page)

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F 0655 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of Resident #25's medical records revealed Nurse #3 completed the nursing admission evaluation dated 10/05/23 and a skilled nursing charting document dated 10/06/23. There was no baseline care plan in the medical records that was completed within the first 48 hours of admission on 10/05/23 that included dietary, or physician orders related to diagnoses diabetes mellitus and severe protein-calorie malnutrition for Resident #25. The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #25 was cognitively intact and independent with eating with no known weight loss or gain. During an interview on 06/27/24 at 4:18 PM Nurse #3 revealed the baseline care plan was completed on the first or second day after admission. She revealed the computer system automatically populated which residents needed a baseline care plan to be completed but must not have triggered her to complete one for Resident #25. She confirmed she was the assigned nurse for Resident #25 that would have completed the baseline care plan on either 10/05/24 or 10/06/24 and she did not. Nurse #3 was unsure who followed up to ensure the resident's baseline care plans were completed and revealed it depended on the nurse working who was assigned to complete it. The former DON was no longer employed and unable to be interviewed. During an interview on 06/27/24 at 6:12 PM, the Regional Nurse Consultant and Administrator stated it was the responsibility of the admitting nurse to complete and review the baseline care plan with the resident or their Responsible Party within 48 hours of admission.

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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** 37014 Based on record review and staff interviews, the facility failed to develop individualized, comprehensive care plans that included areas of focus for nutritional risk and indwelling catheter for 2 of 5 residents reviewed for nutrition and urinary catheters (Resident #2 and Resident #22). Findings included: 1. Resident #2 was admitted to the facility on [DATE] with diagnoses that included urinary retention and dementia. A physician's diet order for Resident #2 dated 03/29/24 read in part, regular diet with pureed texture and regular/thin liquids. A physician's order for Resident #2 dated 03/29/24 read in part, suprapubic catheter (flexible tube that enters the body through a small incision in the abdomen that helps drain urine from the bladder) one time a day. The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #2 had intact cognition. He was dependent on staff assistance for all self-care tasks, including eating. He had an indwelling catheter and received a mechanically altered diet. The urinary catheter Care Area Assessment (CAA) associated with the admission MDS assessment dated [DATE] revealed in part, Resident #2 had an indwelling catheter that would be addressed in the care plan. The nutritional status CAA associated with the admission MDS assessment dated [DATE] revealed in part, Resident #2 received a mechanically altered diet. It was noted Resident #2's nutritional status would be addressed in the care plan. Review of Resident #2's comprehensive care plan on 06/24/24 at 2:15 PM revealed no plans that addressed nutrition or catheter. During a telephone interview on 06/26/24 at 4:25 PM, the Regional MDS Consultant revealed the facility did not currently have a MDS Coordinator onsite at the facility and she completed the MDS assessments and care plans remotely along with the assistance of 2-3 MDS staff that worked on an as needed basis. The Regional MDS Consultant explained that she liked to have nutrition care plans completed for all residents to address nutritional risk or risk of nutritional alteration; however, they discovered the previous Registered Dietician had not completed nutrition care plans. The Regional MDS Consultant confirmed she was the one who completed Resident #2's admission MDS assessment dated [DATE] and both nutrition and catheter should have been care planned since they triggered on his admission MDS assessment. The Regional MDS Consultant explained she had started Resident #2's comprehensive care plan but did not get it finished and ultimately, it was the responsibility of MDS staff to ensure that care plans were comprehensive and completed regardless of who contributed to the care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a joint interview on 06/27/24 at 6:12 PM, the Regional Clinical Nurse Consultant and Administrator both stated they expected care plans to be developed, implemented and accurately reflect a resident's current status. 2. Resident #22 was admitted on [DATE] with diagnoses including diabetes, end-stage renal disease and dependence on renal dialysis. A physician's diet order for Resident #22 read in part, regular texture and regular/thin liquids consistency. Order from dialysis - diabetic diet, add large meat and egg portions to all meals due to low albumin (protein in blood plasma). The admission MDS assessment dated [DATE] revealed Resident #22 had intact cognition. He required partial/moderate to substantial/maximal assistance with self-care tasks and mobility. Further review revealed Resident #22 received dialysis services and a therapeutic diet. The nutritional status CAA associated with the admission MDS assessment dated [DATE] revealed in part, Resident #22 received a therapeutic diet that would be addressed in the care plan. Review of Resident #22's comprehensive care plan on 06/24/24 at 2:15 PM revealed no plan that addressed nutrition. During a telephone interview on 06/26/24 at 4:25 PM, the Regional MDS Consultant revealed the facility did not currently have a MDS Coordinator onsite at the facility and she completed the MDS assessments and care plans remotely along with the assistance of 2-3 MDS staff that worked on an as needed basis. The Regional MDS Consultant explained that she liked to have nutrition care plans completed for all residents to address nutritional risk or risk of nutritional alteration; however, they discovered the previous Registered Dietician had not completed nutrition care plans. The Regional MDS Consultant reviewed Resident #22's comprehensive care plan, confirmed it did not contain a plan to address his nutritional risk and stated one should have been developed. The Regional MDS Consultant stated it was the responsibility of MDS staff to ensure that care plans were comprehensive and completed regardless of who contributed to the care plan. During a joint interview on 06/27/24 at 6:12 PM, the Regional Clinical Nurse Consultant and Administrator both stated they expected care plans to be developed, implemented and accurately reflect a resident's current status.

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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** 37538 Based on observations, record review, and interviews with the Nurse Practitioner (NP) and staff the facility failed to obtain a physician's order for the administration of heparin (an anticoagulant medication) used by Nurse #1 to flush the peripherally inserted central catheter for 1 of 5 residents reviewed for unnecessary medications (Resident #25). Findings included: Resident #25 was admitted to the facility on [DATE] with diagnoses including diabetes mellitus and pulmonary embolism. The care plan last reviewed 3/22/24 included Resident #25 was at risk for complications related to anticoagulant therapy for the use of apixaban with the goal to have no adverse reactions to the medication. Interventions included administer as ordered by the physician and monitor for side effects signs of bleeding and bruising. Review of Resident #25's current physician orders included the administration of apixaban (an anticoagulant medication) give 5 milligrams (mg) twice a day for atrial fibrillation started on 10/05/23 and 4.5 grams of piperacillin sodium-tazobactam was administered intravenously every 6 hours via PICC line for urinary tract infection started on 06/19/24. There was no current physician's order in place for flushing/locking the PICC line when heparin was used. Review of the June 2024 Medication Administration Record revealed nurses initialed apixaban 5 mg was administered twice a day and 4.5 grams of piperacillin sodium-tazobactam was administered intravenously every 6 hours via PICC line with the first dose given on 06/19/24 at 6:00 PM and the last dose given on 06/26/24 at 6:00 AM for 27 administrations. During an observation on 06/25/24 at 3:25 PM Nurse #1 entered Resident #25's room and revealed she came to disconnect the antibiotic medication and flush the PICC line. Nurse #1 was observed to flush the line with a prefilled syringe of 5 milliliters of heparin. During an interview on 06/27/24 at 5:49 PM Nurse #1 stated there was no written physician's order for the use of heparin to flush the PICC line of Resident #25. She stated it was the facility's policy to flush PICC lines using this method to keep it patent. The former Director of Nursing was no longer employed and unable to be interviewed. A phone interview was conducted on 06/27/24 at 6:03 PM with Nurse Practitioner (NP) #1. NP #1 stated she would want an order for the administration of heparin to include the dose amount Nurse #1 should use to flush the PICC line. NP #1 revealed the facility policy for central catheter flushing included information on the which method to use when flushing PICC lines. NP #1 stated Resident #25 was taking the anticoagulant medication apixaban and a physician's order for the dose amount of heparin was needed when administered via PICC line.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37538 Based on record review, interviews with the Registered Dietitian (RD) and staff, the facility failed to implement the recommendation for a protein supplement and failed to administer the correct amount of a nutritional supplement as ordered by the physician for 2 of 3 residents reviewed for nutrition (Resident #25 and #51). Findings included: 1. Resident #25 was admitted to the facility on [DATE] with diagnoses including diabetes mellitus and severe protein calorie malnutrition. A nutrition/dietary note dated 10/27/23 revealed a recommendation was made to administer 30 milliliters (ml) of liquid protein twice a day related to severe calorie-protein malnutrition. Review of the current physician orders included an order for the administration of a liquid protein with directions to give 30 ml twice a day due to severe calorie-protein malnutrition with a start date 10/30/23. Review of the Medication Administration Record (MAR) from [DATE] through June 2024 revealed the physician's order dated 10/30/23 for liquid protein was not transcribed to the MAR and was not documented as being administered. The care plan last reviewed on 03/22/24 identified Resident #25 was at risk for an overall nutritional decline and weight fluctuations with the goal to have no significant weight loss or gain through the next review. Interventions included provide supplements as ordered and administer medications as ordered. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #25 was cognitively intact and independent with eating with no known weight loss or gain. A nutrition/dietary note dated 06/18/24 documented by the RD revealed Resident #25's oral meal intake was adequate for needs and a gradual long term weight loss was identified, and the recommendation was to continue liquid protein 30 ml twice a day. An interview was conducted on 06/27/24 at 1:41 PM with the RD who documented the nutritional/dietary note dated 06/18/24. The RD revealed she recommended liquid protein for Resident #25 based on a diagnosis of malnutrition and not for weight loss or skin breakdown. She revealed a hospital lab result on 10/02/23 the total protein was 6.4 (the amount of two proteins in the blood with normal range 6.0 to 8.3 grams per deciliter) and albumin 3.1 (the amount of protein in the blood with normal range 3.4 to 5.4 grams per deciliter). Since the recommendation for liquid protein was not followed from 10/30/23 through (06/27/24) the RD stated she was going to discontinue it and obtain a comprehensive metabolic panel to determine the current total protein and albumin levels and she believed there was no negative outcome based on Resident #25 had no current skin breakdown. The RD revealed her recommendations were sent via email to the Director of Nursing (DON), the Regional MDS Coordinator, and the Dietary Manager and stated she did want the facility to follow dietary recommendations she made. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 06/27/24 at 6:26 PM with the Administrator and Regional Nurse Consultant. The Regional Nurse Consultant stated the RD recommendations should be followed. She revealed the RD emailed recommendations to the facility and the Unit Managers provided the recommendation to the Medical Doctor who let them know if they want to implement the recommendation or not and if yes, an order was written. 2. Resident #51 was admitted to the facility 04/25/24 with diagnoses including cerebrovascular accident and dysphagia. Review of the current physician orders included enteral feedings after meals and at bedtime with directions to administer 1.5 calorie nutritional supplement via percutaneous endoscopic gastrostomy (a tube place in the stomach used to provide nutrition) and to give 270 ml when oral intake was less than 50% with a start date of 04/25/24. Review of the nutrition/dietary note dated 04/30/24 revealed Resident #51 received a regular diet of puree texture and nectar thickened liquids and oral intake ranged from 0 to 25% for most meals. The RD noted 1.5 calorie nutritional supplement enteral feedings were received four times a day if intake of meals was less than 50% and recommended the current plan of care was adequate to meet nutritional needs and made no new recommendations. The care plan last reviewed on 05/02/24 identified Resident #51 had a potential nutritional problem related to tube feeding and decreased oral intake with the goal to not have significant weight loss or gain through next review. Interventions included provide and serve supplements as ordered and the RD to evaluate and make diet change recommendations as needed. Review of the nutrition/dietary note dated 05/17/24 revealed Resident #51's diet remained the same puree texture and nectar-thickened liquids and oral intake continued to be 0 to 50% of meals. The nutritional supplement 1.5 calorie enteral feedings were received four times a day if intake of meals was less than 50%. The RD note revealed the current plan of care was adequate to meet nutritional needs and made no new recommendations. Review of the documented weights in the medical records of Resident #51 were as follows: 5/11/24 weight 117.8 pounds. 5/27/24 weight 117.2 pounds. 6/6/24 weight 117 pounds. The quarterly MDS assessment dated [DATE] revealed Resident #51 cognition was severely impaired. Resident #51 needed substantial to maximum assistance with eating and received 51% or more calories through a feeding tube with no known weight loss or gain. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A continuous observation was made on 06/27/24 at 12:56 PM through 1:11 PM of Nurse #5 administering an enteral feeding to Resident #51. Nurse #5 administered one carton of a 1.5 calorie nutritional supplement containing 237 ml and stated it was reported Resident #51 ate less than 25% of the meal and confirmed she administered 237 ml of the nutritional supplement. Nurse #5 was asked to review the physician's order for the correct amount of nutritional supplement to be administered. After review of the order Nurse #5 stated the order was to give 270 ml and she would notify the Nurse Practitioner for guidance. A follow-up interview was conducted on 06/27/24 at 2:39 PM with Nurse #5. Nurse #5 revealed she had notified the on-call provider and received a new order for enteral feedings after meals and at bedtime when oral intake was less than 50% to administer 1.5 calorie nutritional supplement and give 237 ml via feeding tube. An interview was conducted on 06/27/24 at 1:32 PM with the RD. The RD was informed Resident #52 received 237 ml of the nutritional supplement during an observation of a enteral feeding. The RD stated with each enteral feeding if the nurses consistently gave 237 ml Resident #51's nutritional needs were still being met and what they gave the resident was more than her nutritional needs were. The RD revealed the recommendation probably needed to change from 270 ml to 237 ml to prevent having to open another container. The RD stated she did want diet recommendations followed but there was no negative outcome to Resident #51. An interview was conducted on 06/27/24 at 6:26 PM with the Administrator and Regional Nurse Consultant. The Regional Nurse Consultant stated the RD recommendations should be followed. She revealed the RD emailed recommendations to the facility and the Unit Managers provided the recommendation to the Medical Doctor who let them know if they want to implement the recommendation or not and if yes, an order was written.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37014 Based on record review and staff interviews, the facility failed to ensure physician visits were performed every 30 days for the first 90 days of admission for 6 of 12 sampled residents reviewed for physician visits (Residents #2, #16, #22, #23, #11, and #25). Findings included: a. Resident #2 was admitted to the facility on [DATE] with diagnoses that included cerebrovascular disease (conditions that affect blood flow to the brain), dysphagia (trouble swallowing), hypertension, and dementia. Review of Resident #2's Electronic Medical Record (EMR) revealed no evidence he was seen by the facility's Medical Doctor (MD) since his admission on 03/29/24. Review of Resident #2's EMR revealed he was seen by the Nurse Practitioner (NP) on 03/29/24, 05/06/24, 05/22/24, and 06/20/24. The Director of Nursing was no longer employed and unable to be interviewed. The facility's MD was out of the country and unable to be interviewed. During an interview on 06/26/24 at 1:39 PM and follow-up interview on 06/27/24 at 1:35 PM, the Regional Clinical Nurse Consultant revealed she reviewed Resident #2's electronic medical record and verified Resident #2 had not been seen by the facility's MD since his admission on 03/29/24 but he had been seen by the NP. The Regional Clinical Nurse Consultant stated from what she understood the MD was keeping track of his own schedule for when regulatory visits were due and when the MDS Coordinators noticed physician visits were not being completed, the Medical Records staff member conducted an audit of provider visits. She explained that the Medical Records staff member was unaware of the regulation requiring residents to be seen by the MD monthly during the first 90 days of admission and was only keeping track of when residents were last seen by the MD or NP. The Regional Clinical Nurse Consultant stated that going forward, the Medical Records staff member would be responsible for keeping track of when residents were seen and when they needed to be seen by the MD for regulatory visits. During an interview on 06/27/24 at 8:43 AM, the Medical Records Director stated around March 2024 it was discovered that there was an issue with physician visits being completed and she was asked to do an audit. She stated she only looked at when residents were last seen by the MD or NP and that was what she had kept track of from that point on. The Medical Records Director stated she was informed yesterday (06/26/24) that she would be responsible for keeping track of a MD schedule for regulatory visits. b. Resident #16 was admitted to the facility on [DATE] with diagnoses that included diabetes, cirrhosis of liver, dependent personality disorder, chronic pain, and acquired absence of right leg below knee. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #16's Electronic Medical Record (EMR) revealed he was seen by the facility's Medical Doctor (MD) on 06/10/24. There was no other evidence of physician visits conducted by the MD following Resident #16's admission to the facility. Review of Resident #16's EMR revealed he was seen by Nurse Practitioner (NP) on 04/22/24, 04/29/24, 05/17/24, 05/23/24, 06/04/24, and 06/05/24. The Director of Nursing was no longer employed and unable to be interviewed. The facility's MD was out of the country and unable to be interviewed. During an interview on 06/26/24 at 1:39 PM, the Regional Clinical Nurse Consultant revealed she reviewed Resident #16's electronic medical record and confirmed Resident #16 had only been seen once by the facility's MD (06/10/24) since his admission on 04/20/24 but he had been seen by the NP. The Regional Clinical Nurse Consultant stated from what she understood the MD was keeping track of his own schedule for when regulatory visits were due and when the MDS Coordinators noticed physician visits were not being completed, the Medical Records staff member conducted an audit of provider visits. She explained that the Medical Records staff member was unaware of the regulation requiring residents to be seen by the MD monthly during the first 90 days of admission and was only keeping track of when residents were last seen by the MD or NP. The Regional Clinical Nurse Consultant stated that going forward, the Medical Records staff member would be responsible for keeping track of when residents were seen and when they needed to be seen by the MD for regulatory visits. During an interview on 06/27/24 at 8:43 AM, the Medical Records Director stated around March 2024 it was discovered that there was an issue with physician visits being completed and she was asked to do an audit. She stated she only looked at when residents were last seen by the MD or NP and that was what she had kept track of from that point on. The Medical Records Director stated she was informed yesterday (06/26/24) that she would be responsible for keeping track of a MD schedule for regulatory visits. c. Resident #22 was admitted to the facility on [DATE] with diagnoses that included diabetes, end-stage renal disease, dependence on renal dialysis, chronic kidney disease, and an infection that attacks the body's immune system. Review of Resident #22's Electronic Medical Record (EMR) revealed he was seen by the facility's Medical Doctor (MD) on 06/11/24. There was no other evidence of physician visits conducted by the MD following Resident #22's admission to the facility. Review of Resident #22's EMR revealed he was seen by Nurse Practitioner (NP) on 04/17/24, 05/22/24, and 06/20/24. The Director of Nursing was no longer employed and unable to be interviewed. The facility's MD was out of the country and unable to be interviewed. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/26/24 at 1:39 PM, the Regional Clinical Nurse Consultant revealed she reviewed Resident #22's electronic medical record and verified Resident #22 had only been seen once by the facility's MD (06/11/24) since his admission on 04/16/24 but he had been seen by the NP. The Regional Clinical Nurse Consultant stated from what she understood the MD was keeping track of his own schedule for when regulatory visits were due and when the MDS Coordinators noticed physician visits were not being completed, the Medical Records staff member conducted an audit of provider visits. She explained that the Medical Records staff member was unaware of the regulation requiring residents to be seen by the MD monthly during the first 90 days of admission and was only keeping track of when residents were last seen by the MD or NP. The Regional Clinical Nurse Consultant stated that going forward, the Medical Records staff member would be responsible for keeping track of when residents were seen and when they needed to be seen by the MD for regulatory visits. During an interview on 06/27/24 at 8:43 AM, the Medical Records Director stated around March 2024 it was discovered that there was an issue with physician visits being completed and she was asked to do an audit. She stated she only looked at when residents were last seen by the MD or NP and that was what she had kept track of from that point on. The Medical Records Director stated she was informed yesterday (06/26/24) that she would be responsible for keeping track of a MD schedule for regulatory visits. d. Resident #23 was admitted to the facility on [DATE] with diagnoses that included acute kidney failure, diffuse traumatic brain injury with loss of consciousness of unspecified duration, hypertension, bipolar disorder, and impulse disorder. Review of Resident #23's Electronic Medical Record (EMR) revealed he was seen by the facility's Medical Doctor (MD) on 03/27/24 and 04/10/24. There was no other evidence of physician visits conducted by the MD following Resident #23's admission to the facility. Review of Resident #23's EMR revealed he was seen by Nurse Practitioner (NP) on 03/27/24, 05/27/24, 06/07/24, and 06/20/24. The Director of Nursing was no longer employed and unable to be interviewed. The facility's MD was out of the country and unable to be interviewed. During an interview on 06/26/24 at 1:39 PM, the Regional Clinical Nurse Consultant revealed she reviewed Resident #23's electronic medical record and verified in addition to the NP visits, Resident #23 was seen by the facility's MD on 03/27/24 and 04/10/24. She stated that Resident #23 should have been seen by the MD in May 2024 but there was no documentation of a MD visit. The Regional Clinical Nurse Consultant stated from what she understood the MD was keeping track of his own schedule for when regulatory visits were due and when the MDS Coordinators noticed physician visits were not being completed, the Medical Records staff member conducted an audit of provider visits. She explained that the Medical Records staff member was unaware of the regulation requiring residents to be seen by the MD monthly during the first 90 days of admission and was only keeping track of when residents were last seen by the MD or NP. The Regional Clinical Nurse Consultant stated that going forward, the Medical Records staff member would be responsible for keeping track of when residents were seen and when they needed to be seen by the MD for regulatory visits. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/27/24 at 8:43 AM, the Medical Records Director stated around March 2024 it was discovered that there was an issue with physician visits being completed and she was asked to do an audit. She stated she only looked at when residents were last seen by the MD or NP and that was what she had kept track of from that point on. The Medical Records Director stated she was informed yesterday (06/26/24) that she would be responsible for keeping track of a MD schedule for regulatory visits. e. Resident #11 was admitted to the facility on [DATE] with diagnoses that included hemiplegia and hemiparesis following cerebral infarction (stroke) affecting the left non-dominant side, diabetes, vascular dementia, psychotic disturbance, and anxiety. Review of Resident #11's Electronic Medical Record (EMR) revealed he was seen by the facility's Medical Doctor (MD) on 08/14/23, 01/19/24, and 02/19/24. In addition, there were two progress notes which indicated Resident #11 was seen by the MD in conjunction with the Nurse Practitioner (NP) on 12/07/23 and 03/28/24. Other than the physician progress note dated 08/14/23, there was no other evidence of physician visits conducted by the MD every 30 days for the first 90 days following Resident #11's admission to the facility. Review of Resident #11's EMR revealed he was seen by the NP on 12/07/23, 03/28/24, 04/16/24, and 05/29/24. The Director of Nursing was no longer employed and unable to be interviewed. The facility's MD was out of the country and unable to be interviewed. During an interview on 06/26/24 at 1:39 PM, the Regional Clinical Nurse Consultant revealed she reviewed Resident #11's electronic medical record and verified in addition to the NP visits, Resident #11 was seen by the facility's MD on 01/19/24 and 02/19/24. She stated there was no other documentation of MD visits. The Regional Clinical Nurse Consultant stated from what she understood the MD was keeping track of his own schedule for when regulatory visits were due and when the MDS Coordinators noticed physician visits were not being completed, the Medical Records staff member conducted an audit of provider visits. She explained that the Medical Records staff member was unaware of the regulation requiring residents to be seen by the MD monthly during the first 90 days of admission and was only keeping track of when residents were last seen by the MD or NP. The Regional Clinical Nurse Consultant stated that going forward, the Medical Records staff member would be responsible for keeping track of when residents were seen and when they needed to be seen by the MD for regulatory visits. During an interview on 06/27/24 at 8:43 AM, the Medical Records Director stated around March 2024 it was discovered that there was an issue with physician visits being completed and she was asked to do an audit. She stated she only looked at when residents were last seen by the MD or NP and that was what she had kept track of from that point on. The Medical Records Director stated she was informed yesterday (06/26/24) that she would be responsible for keeping track of a MD schedule for regulatory visits. 37538 f. Resident #25 was admitted to the facility on [DATE] with diagnoses including diabetes mellitus and severe protein-calorie malnutrition. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical records for Resident #25 revealed physician progress notes dated 01/11/24, 02/15/24, and 03/31/24 to indicate she was seen by the facility's Medical Doctor (MD). There was no other evidence in the medical records of Resident #25 of physician visits conducted by the MD. Review of the medical records for Resident #25 revealed she was seen by the NP on 10/5/23, 11/11/23, 12/13/23, 3/19/24, 4/4/24, and 5/24/24. The Director of Nursing was no longer employed and unable to be interviewed. The facility's MD was out of the country and unable to be interviewed. During an interview on 06/26/24 at 1:39 PM, the Regional Clinical Nurse Consultant revealed the MD kept track of his own schedule for when regulatory visits were due. She revealed when the MDS Coordinators noticed physician visits were not being completed, the Medical Records staff member conducted an audit of provider visits. She explained the Medical Records staff member was unaware of the regulation requirements residents needed to be seen by the MD monthly during the first 90 days of admission and only kept track of when residents were last seen by the MD or NP. She stated going forward, the Medical Records staff member would be responsible for keeping track of when residents were seen and when they needed to be seen by the MD for regulatory visits. During an interview on 06/27/24 at 8:43 AM, the Medical Records Director stated around March 2024 an issue with physician visits being completed was discovered and she was asked to do an audit. She only looked at when residents were last seen by the MD or NP and stated that was what she had kept track of from that point on. She revealed on 06/26/24 she was informed she would be responsible for keeping track of a MD schedule for regulatory visits.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 37014 Based on record review and staff interviews, the facility failed to ensure Registered Nurse (RN) coverage was provided for at least 8 consecutive hours per day for 6 of 85 days reviewed (Dates 04/27/24, 04/28/24, 05/20/24, 05/21/24, 05/26/24, and 06/08/24). Findings included: Review of the daily nurse staffing sheets and associated time clock reports for the period 04/01/24 through 06/24/24 revealed the facility did not have the required RN coverage on the following dates: 04/27/24, 04/28/24, 05/20/24, 05/21/24, 05/26/24, and 06/08/24. During an interview on 06/27/24 at 3:53 PM, the Scheduling Coordinator revealed she took over handling the Skilled Nursing staff schedules on 03/18/24 and was usually able to ensure there was an RN scheduled daily anywhere from 8 to 12 hours. The Scheduling Coordinator stated the only time there wouldn't be the required RN coverage was when the RN scheduled called out of work. During an interview on 06/26/24 at 9:34 AM and a joint interview with the Administrator on 06/27/24 at 6:12 PM, the Regional Clinical Nurse Consultant acknowledged that the facility did not have the required RN coverage on 04/27/24, 04/28/24, 05/20/24, 05/21/24, 05/26/24, and 06/08/24. She explained that most of the days without coverage occurred during the weekend and was due to the weekend RN supervisor resigning. The Regional Clinical Nurse Consultant revealed since the new corporation took over in September 2023, they have had trouble maintaining a stable nurse administration team, specifically the Director of Nursing position, which caused things to get overlooked. She stated they now have sufficient RN staff to ensure the required RN coverage was met consistently.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 37014 Based on record review and staff interviews, the facility failed to ensure daily nurse staffing sheets were filled out completely for 27 of 123 days reviewed during the period 10/01/23 through 01/31/24. Findings included: Review of the facility's daily nurse staffing sheet revealed underneath the facility's name was a space to specify the date and current resident census. In addition, there were columns to complete that specified the number of staff and hours worked for Registered Nurses (RNs), Licensed Practical Nurses (LPNs) and Certified Nursing Assistants (CNAs) for each 12-hour shift, 7:00 AM to 7:00 PM and 7:00 PM to 7:00 AM. Review of the daily nurse staffing sheets for 10/03/23, 10/21/23, 10/22/23, 10/26/23, and 10/31/23 revealed written at the bottom of each nurse staffing sheet was the total daily number of hours worked for RNs, LPNs, and CNAs. The columns for each shift indicating the number of staff and hours worked for RNs, LPNs, and CNAs were left blank. Review of the daily nurse staffing sheets for 11/02/23, 11/08/23, 11/12/23, 11/14/23, 11/18/23, 11/19/23, 11/24/23, 11/27/23, 11/28/23, 11/29/23, and 11/30/23 revealed written at the bottom of each nurse staffing sheet was the total daily number of hours worked for RNs, LPNs, and CNAs. The columns for each shift indicating the number of staff and hours worked for RNs, LPNs, and CNAs were left blank. Review of the daily nurse staffing sheets for 12/12/23, 12/14/23, 12/16/23, 12/18/23, 12/27/23, 12/30/23, and 12/31/23 revealed written at the bottom of each nurse staffing sheet was the total daily number of hours worked for RNs, LPNs, and CNAs. The columns for each shift indicating the number of staff and hours worked for RNs, LPNs, and CNAs were left blank. Review of the daily nurse staffing sheets for 01/04/24, 01/09/24, 01/16/24, and 01/26/24 revealed written at the bottom of each nurse staffing sheet was the total daily number of hours worked for RNs, LPNs, and CNAs. The columns for each shift indicating the number of staff and hours worked for RNs, LPNs, and CNAs were left blank. During an interview on 06/27/24 at 3:53 PM, the Scheduling Coordinator revealed she took over handling the Skilled Nursing staff schedules on 03/18/24 which includes completing and maintaining daily nurse staffing sheets. The Scheduling Coordinator explained when she looked through the staffing information kept by the previous Scheduler, she was unable to locate the completed nurse staffing sheets for the dates 10/03/23, 10/21/23, 10/22/23, 10/26/23, 10/31/23, 11/02/23, 11/08/23, 11/12/23, 11/14/23, 11/18/23, 11/19/23, 11/24/23, 11/27/23, 11/28/23, 11/29/23, 11/30/23, 12/12/23, 12/14/23, 12/16/23, 12/18/23, 12/27/23, 12/30/23, 12/31/23, 01/04/24, 01/09/24, 01/16/24, and 01/26/24. She stated since they were unable to locate the missing nurse staffing sheets, one was filled out for each date with the total number of hours worked for that day noted at the bottom of the sheet. (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	During an interview on 06/26/24 at 9:34 AM and joint interview with the Administrator on 06/27/24 at 6:12 PM, the Regional Clinical Nurse Consultant stated it was the responsibility of the Scheduler to ensure daily nurse staffing sheets were completed, accurate and maintained per regulation. The Regional Clinical Nurse Consultant revealed since the new corporation took over in September 2023, they have had trouble maintaining a stable nurse administration team, specifically the Director of Nursing position, which caused things to get overlooked. She stated it would take some time but the facility would get processes put into place to achieve compliance.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 36217 Based on record review and interviews with resident, staff, and the Nurse Practitioner (NP), the facility failed to pull controlled medications from the medication cart and returned them to the pharmacy after the resident was deceased . As a result, controlled medications of a deceased resident remained in the medication cart were targeted and diverted for 1 of 1 resident reviewed for pharmacy services (Resident #113). The findings included: Resident #113 was admitted to the facility on [DATE] with diagnoses including thrombocytopenia. He passed away in the facility on [DATE]. A review of the physician's order dated [DATE] revealed Resident #113 had an order to receive 5 mg of oxycodone by mouth once every 12 hours for moderate to severe pain. This order was discontinued on [DATE]. A review of the MARs for [DATE] revealed Resident #113 had received oxycodone 5 mg once on [DATE]. The admission MDS dated [DATE] coded Resident #113 with an intact cognition. A review of the controlled substance count sheet for Resident #113's oxycodone revealed his oxycodone was signed out by different nurses three times on [DATE], one time on [DATE], and one time on [DATE]. Further review of the signatures in the controlled substance count sheet revealed they could have been written by the same person based on similarities of the ink and handwriting. The initial allegation report dated [DATE] revealed the facility became aware of the misappropriation of residents' property on [DATE] at 3:30 PM when the Administrator and the DON were notified that Nurse #7 had stolen 1 tablet of oxycodone 5 mg from Resident #58 and 5 tablets of oxycodone 5 mg from Resident #113 who had expired 12 days ago. The 5-day investigation report dated [DATE] revealed Nurse #7 was normal when she reported to duty on [DATE]. About 2 hours after she started her shift, she appeared to be under the influence of unknown substances. As Nurse #7 was too impaired to complete her work safely, the Unit Manager (UM) reported the incidents to the Administrator and DON and obtained an order to send her home and placed on do not return status with the agency. Nurse #3 who assumed the medication cart from Nurse #7 found that 1 tablet of oxycodone 5 mg for Resident #58 was signed out using her name when she did not have access to that medication cart. Resident #58 was able to attest to the fact that Nurse #3 did not give her any oxycodone that morning. Nurse #3 called both the DON and Administrator for her findings. The allegation of misappropriation of residents' property was substantiated based on empirical evidence and witness statements. The Sheriff's office was reported, and Nurse #3 was instructed to do a review of all controlled substance count sheets with that medication cart. She discovered Resident #113 who was deceased on [DATE] had 5 tablets of oxycodone 5 mg signed out with several different nurses' names fraudulently. The staffing agency and NCBON were notified immediately. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with Nurse #3 on [DATE] at 3:43 PM. She stated Nurse #7 appeared to be under influence with confusion and having erratic behavior after working for about 2 hours on [DATE]. The UM called the Administrator and received the order to send Nurse #7 home at approximately 2 PM as she was incompetent to carry out her duty as a nurse. She counted the controlled medications in the medication cart with Nurse #7 before she left the halls, and it was without discrepancies. After Nurse #7 had left the halls, Resident #58 asked for her as needed oxycodone at around 3:30 PM. She found that one tablet of oxycodone 5 mg was signed out under her name at 9:30 AM that morning, when she did not have access to the medication cart at that time. The signature was faked and looked very different from her signatures in the narcotic count sheets. Resident #58 confirmed that she did not receive oxycodone from any nurses that morning with a written statement. After identifying discrepancies in narcotic count sheets for Resident #58, she quickly checked other sheets in the same cart and found that Resident #113 who had passed away on [DATE], had three tablets of oxycodone 5 mg signed out on [DATE], one tablet on [DATE], and one tablet on [DATE] with signatures of several different nursing staff. She confirmed the signatures were faked by calling all the nursing staff whose names appeared on the narcotic count sheet. During an interview conducted on [DATE] at 4:20 PM, Nurse #1 stated she was the UM when the incident on [DATE] occurred. She indicated that after a resident deceased , the nurse in-charge was responsible to pull the medications from the medication cart within 24 hours and store them in the designated secured compartment. Then returned the pulled medications to the pharmacy within 72 hours. She did not understand why the controlled medications for Resident #113 were still in the medication cart after he had deceased for almost 2 weeks. An interview was conducted with NP #2 on [DATE] at 12:10 PM. She expected the facility to have a system in place and properly implemented to account for the receipt, disposition, and reconciliation of all controlled medication to prevent or deter drug diversions. During an interview conducted on [DATE] at 1:14 PM, the Acting DON acknowledged that she was the nurse in-charge providing care for Resident #113 when he expired on [DATE]. She could not recall if she had pulled Resident #113's medications in the medication cart on the same day. However, it was her expectation for the nurse in-charge to pull medications for residents who had deceased immediately and return them to the pharmacy within 3 days. An interview was conducted with the Administrator on [DATE] at 1:54 PM. He expected nursing staff to remove controlled medications for residents who had deceased within 24 hours and return them to the pharmacy within 72 hours.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 36217 Based on observation, staff interviews, and record reviews, the facility failed to secure an opened bottle of Silvadene cream for 1 of 1 Resident (Resident # 30) review for medication storage, failed to removed expired over-the-counter (OTC) medications in accordance with the manufacturer's expiration date for 1 of 2 medication storage rooms and 1 of 4 medication carts (Upper medication storage room and Upper C halls medication cart), failed to remove expired insulin as specified by the manufacturer's guidelines for 1 of 4 medication carts (Upper C halls), and failed to store insulins and eye drops in the temperature specified by the manufacturer's guidelines in 3 of 4 medication carts during medication storage checks (Upper C halls, Lower C halls, and Lower D halls). The findings included: a. During a joint observation conducted with Nurse #2 on 06/23/24 at 9:51 AM, an opened bottle of Silvadene cream 1% containing approximately 10 grams was left unattended on the top of the bedside table in Resident #30's room. An interview was conducted with Resident #30 on 06/23/24 at 9:58 AM. She did not know who had left the cream in her room and how long it had been left unattended. During an interview conducted on 06/23/24 at 10:09 AM, Nurse #2 stated the Silvadene cream should be stored in the treatment cart and not to be left unattended in Resident #30's room. An interview was conducted with MA #1 on 06/23/24 at 10:31 AM. She did not notice the cream was left unattended in Resident #30's room when she did medication pass in the morning. She added the Silvadene cream should be stored in the treatment cart after it had been used. b. A medication storage audit was conducted on 06/25/24 at 10:48 AM in the presence of Nurse #3. The following medication were found in Upper medication storage room and ready to be used: 1. Two unopened bottles of zinc oxide barrier cream expired on 04/30/24. Each bottle contained 16 ounces (oz). 2. One unopened bottle of calcium 500 milligrams (mg) containing 60 tablets expired on 02/29/24. 3. One unopened bottle of multivitamin with zinc containing 60 tablets expired on 05/31/24. 4. Two unopened bottles of calcium 600 mg with Vitamin D expired on 03/31/24. Each bottle contained 60 tablets. 5. Five packets of Neosporin ointment expired on 05/31/24. Each packet contained 0.9 grams. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with Nurse #3 on 06/25/24 at 10:59 AM. She did not know any nurses had been assigned or designated to check the medication storage room on a regular basis. She acknowledged that those expired medications needed to be removed from the shelf and returned to the pharmacy. c. During a medication storage audit conducted on 06/25/24 at 11:10 AM in the presence of Nurse #4. The following medications were found expired or stored in an inappropriate temperature in Upper C halls medication cart and ready to be used: 1. One pen of insulin Lispro KwikPen opened on 04/08/24 that expired on 05/06/24. 2. One opened bottle of Loperamide 2 mg containing 150 tablets expired on 02/29/24. 3. Two unopened bottles of insulin Lantus stored at room temperature for an unknown length of time. Each bottle contained 10 milliliters (ml). 4. One unopened pen of insulin Lantus containing 3 ml stored at room temperature for an unknown length of time. During an interview conducted on 06/25/24 at 11:29 AM, Nurse #4 stated it was the second time she worked at the Upper halls. She did not know how long the insulins had been left in the medication cart. She acknowledged that unopened insulins were supposed to be stored in the refrigerator until they were ready to be used. She explained she planned to check the medication cart for proper storage and expiration in the morning, but she did not have the time to do it. d. A medication storage audit was conducted on 06/25/24 at 3:27 PM in the presence of Nurse #1. One unopened pen of insulin Lantus containing 3 ml was found in the Lower C halls medication cart at room temperature for an unknown length of time and ready to be used. An interview was conducted with Nurse #1 on 06/25/24 at 3:29 PM. She could not confirm how long the insulin pen had been left in the medication cart but stated she did not see the insulin pen when she worked on 06/24/24. She acknowledged that unopened insulin should be stored in the refrigerator until it was ready to be used. e. During a medication storage audit conducted on 06/25/24 at 3:45 PM in the presence of Medication Aide (MA) #2, Two unopened bottles of latanoprost eye drops, each containing 2.5 ml were found in the Lower C halls medication cart at room temperature for an unknown length of time and ready to be used. During an interview conducted on 06/25/24 at 3:48 PM, MA #2 did not know who had put the latanoprost eye drops in the medication cart or when it happened. She explained when she checked the medication cart in the morning, she did not see the eye drops in the medication cart. An interview was conducted with the Acting Director of Nursing (DON) on 06/26/24 at 1:14 PM. She expected nursing staff to keep the facility free of expired medication, store all the medications in the proper environment as specified by the manufacturer's guidelines, and keep medications in a safe and controlled environment. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview conducted with the Administrator on 06/25/24 at 1:54 PM, he attributed the incidents to lack of leadership in nursing department due to frequent turnover of DON in recent months. It was his expectation for nursing staff to store all the medications in a proper condition according to the manufacturer's guidelines, keep the facility free of expired or unattended medications.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 37538 Based on observations, record review, and interviews with staff the facility failed to follow their infection control policy and procedures to implement Enhanced Barrier Precaution (EBP) precautions for residents with indwelling medical devices during high-contact care activities of a central line, feeding tube, tracheostomy, and urinary catheter (Resident #25, #51, #18, and #2) and failed to follow their hand hygiene policy and procedure after removing gloves, after handling items potentially contaminated with body fluids, and when moving from a contaminated body site to a clean body site during incontinence care (Resident#36). These failures occurred for 5 of 5 residents reviewed for infection control. Findings included: Review of the facility's enhanced barrier precautions (EBP) policy and procedures with no revision date read in part, It was the facility's policy to implement barrier precautions for the prevention of transmission of multidrug-resistant organisms (MDRO). EBP referred to an infection control intervention designed to reduce the transmission of MDRO that employed targeted gown and glove use during high contact resident care activities. The compliance guidelines revealed for prompt recognition staff would receive training and were expected to comply with the designated precautions. Staff would receive training on high-risk activities and common organisms that require EBP. Initiation of EBP would require a physician's order be obtained for residents with the following indwelling medical devices: central lines, feeding tubes, tracheostomy/ventilator tubes, and urinary catheters. The policy revealed to implement EBP gowns and gloves should be available immediately near or outside the resident's room and referenced high-contact care activities included device care or use of the following: central lines, feeding tubes, tracheostomy/ventilator tubes, and urinary catheters. The policy noted EBP should be used until the discontinuation of the indwelling medical device that placed the resident at higher risk. 1. During an observation on 06/25/24 at 3:25 PM Resident #25 resided in a room where she currently had no roommate. Nurse #1 entered the room and revealed she came to disconnect the antibiotic medication and flush the peripherally inserted central catheter (PICC) line for Resident #25. Nurse #1 was observed to don gloves then wipe the lumen port of the PICC line using an alcohol wipe then flush with a prefilled syringe of normal saline then flush with a prefilled syringe of heparin (an anticoagulant medication used to prevent blood clots). After Nurse #1 flushed the PICC line, she clamped the tubing below the lumen port and removed and discarded her gloves and left the room. She used an alcohol-based hand rub to sanitize her hands. A phone interview was conducted on 06/27/24 at 3:09 PM with Nurse #1. Nurse #1 stated she had performed hand hygiene prior to entering the room of Resident #25 before donning gloves. She revealed she was not aware of any type of precautions that were in place for Resident #25 related to the urinary tract infection or when a PICC line device was in use and flushed. Nurse #1 revealed when she would wear a gown was if she observed the dressing on the PICC was not adhered or had visible drainage. The former Director of Nursing was no longer employed and unable to be interviewed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 06/27/24 at 6:26 PM with the Regional Nurse Consultant/Infection Preventionist in the presence of the Administrator. It was revealed a lab result identified Resident #25 as having a MDRO, and antibiotic treatment had been received via PICC line. The Regional Nurse Consultant/Infection Preventionist revealed she would expect EBP were in place for Resident #25. 2. An observation was made on 06/27/24 at 12:56 PM of the enteral feed for Resident #51 administered by Nurse #5. Nurse #5 entered the room and washed her hands using soap and water prior to donning a pair of gloves. Nurse #5 opened the port cap to gain access to Resident #51's feeding tube and inserted a syringe and administered 30 ml of water then a nutritional supplement then 30 ml of water. After the water flushes and nutritional supplement were administered Nurse #5 replaced the cap to close the feeding tube. Nurse #5 removed her gloves and washed her hands. An interview was conducted on 06/27/24 at 4:34 PM with Nurse #5. Nurse #5 stated she was not aware EBP were needed during the care of a feeding tube. Nurse #5 stated no one had informed her about the use of EBP for the administration of an enteral feed and she was not aware she needed to wear a gown when accessing a feeding tube. During an interview on 6/27/24 at 4:21 PM the Regional Nurse Consultant/Infection Preventionist revealed there had been no staff education provided for EBP. She stated she provided information on EBP and delegated to the former Director of Nursing (DON) to implement but it was not done. The former Director of Nursing was no longer employed and unable to be interviewed. An interview was conducted on 06/27/24 at 6:26 PM with the Regional Nurse Consultant/Infection Preventionist in the presence of the Administrator. The Regional Nurse Consultant revealed EBP should be initiated and in place for the care of Resident #51's feeding tube. 47683 3. Observations made on 6/23/24, 6/24/24, 6/25/24, 6/26/24, and 6/27/24 revealed no Enhanced Barrier Precautions (EBP) signage or personal protective equipment (PPE) (items that include gowns, gloves, masks, and eye shields) cart posted outside of or near Resident #18's room. An observation on 06/27/24 at 11:04 AM of tracheostomy care for Resident #18 with Nurse #3 and Medication Aide (MA) #1 was conducted. Nurse #3 provided tracheostomy care wearing only a surgical mask and sterile gloves and MA #1 helped Nurse #3 wearing only clean gloves and a surgical mask. An interview with MA #1 on 06/27/24 at 2:52 PM revealed that she was not aware of EBP. MA #1 stated that there had been no education regarding enhanced barrier precautions. An interview with Nurse #3 on 06/27/24 at 2:54 PM revealed that there had been no education about EBP she was unaware of what it was and had not heard of it. An interview with the acting Director of Nursing (DON) on 06/27/24 at 3:01 PM revealed she had heard of EBP. The acting DON stated that she did not recall receiving education or instruction that EBP was recommended for residents who had indwelling medical devices such as a tracheostomy. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 6/27/24 at 4:21PM with the Regional Nurse Consultant and Infection Preventionist revealed that there had been no education in facility for enhanced barrier precautions. The Regional Nurse Consultant stated that she handed out the information to the former DON in March 2024 and the EBP were not introduced to the staff after that. She stated that her expectations were that when a new practice such as the EBP was introduced it would be implemented upon receipt. The former DON was not available for interview during the survey. An interview with the Administrator on 6/27/24 at 6:03 PM revealed that his expectation was that the EBP be implemented upon receipt. He stated that the breakdown was the former DON had not implemented the information she was given. 39037 4. Review of the facility's undated policy titled Hand Hygiene read in part as follows: Policy: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. Definitions: Hand hygiene is a general term for cleaning your hands by handwashing with soap and water or the use of an antiseptic hand rub, also known as alcohol-based hand rub (ABHR). Policy Explanation and Compliance Guidelines: Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the hand hygiene table. Hand Hygiene Table: (a). Before applying and after removing personal protective equipment (PPE), including gloves (b). After handling items potentially contaminated with blood or body fluids (c). When, during resident care, moving from a contaminated body site to a clean body site Additional considerations: (a). The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A continuous observation of Nurse Aide (NA) #1 on 06/27/24 from 1:44 PM through 1:55 PM revealed he provided incontinence care for Resident #36. With gloved hands NA #1 cleaned urine from Resident #36's groin and urethra (tube that leads from the bladder to the outside of the body) areas with resident care wipes, placed the used wipes in the trash can, and assisted Resident #36 with rolling onto her right side. NA #1 cleaned stool from Resident #36's buttocks and anus with resident care wipes and placed them in the trash can, removed Resident #36's brief, and assisted her with rolling onto her back. Resident #36 was incontinent of urine again after rolling onto her back. With the same pair of soiled gloves used to clean stool NA #1 began to clean urine from Resident #36's groin with resident care wipes, then he removed the soiled gloves and placed them in the trash can, put clean gloves on, completed cleaning urine from Resident #36's groin and urethra areas with resident care wipes, and assisted Resident #36 with rolling onto her right side again. Resident #36 was incontinent of stool again and NA #1 cleaned stool from her buttocks and anus with resident care wipes. NA #1 was unable to remove all the stool from Resident #36's buttocks and anus so he removed his soiled gloves and placed them in the trash can, obtained a new pack of resident care wipes from Resident #36's drawer, put on clean gloves, and cleaned stool from Resident #36's buttocks and anus with resident care wipes, removed his soiled left glove and applied a clean glove to his left hand, and rolled the soiled bed pad under Resident #36. NA #1 placed a clean brief under Resident #36, removed the soiled bed pad, fastened the clean brief, removed his left glove and applied a clean glove to his left hand, placed bed covers over Resident #36, gathered the trash can liner, removed his gloves, washed his hands, and exited the room with the trash can liner. NA #1 did not apply clean gloves or perform hand hygiene after cleaning urine and stool and did not perform hand hygiene after removing dirty gloves. In an interview with NA #1 on 06/27/24 at 1:57 PM he confirmed he should have changed his gloves after cleaning stool and before he cleaned urine. He stated he had been trained to wash his hands before he began incontinence care and when he completed incontinence care. NA #1 stated he had not been trained to perform hand hygiene each time he removed dirty gloves. An interview with the acting Director of Nursing (DON) on 06/27/24 at 2:24 PM revealed she expected nursing staff to wipe from front to back during incontinence care and to perform hand hygiene each time gloves were removed. An interview with the Regional Nurse Consultant on 06/27/24 at 6:00 PM revealed she expected nursing staff to wipe front to back during incontinence care and to perform hand hygiene each time between removing soiled gloves and before applying clean gloves. 5. An observation of Resident #2's door on 06/27/24 at 2:08 PM revealed no Enhanced Barrier Precautions (EBP) signage or personal protective equipment (PPE) (items including gowns, gloves, masks, and eye shields) cart posted outside of or near Resident #2's room. An observation of indwelling catheter care for Resident #2 by Nurse Aide (NA) #2 was conducted on 06/27/24 at 2:08 PM. NA #2 provided indwelling catheter care wearing only clean gloves. An interview with NA #2 on 06/27/24 at 3:08 PM revealed she was agency staff, and this was her third day of working in the facility. She stated in most facilities where she worked, residents with indwelling catheters were placed on EBP, but she had not received any education from the facility that Resident #2 should be on EBP. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345432	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Bend Health and Rehabilitation	213 Richmond Hill Drive Asheville, NC 28806

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 6/27/24 at 4:21 PM with the Regional Nurse Consultant and Infection Preventionist revealed that there had been no education in the facility for enhanced barrier precautions. The Regional Nurse Consultant stated that she handed out the information to the former DON in March 2024 and the EBP were not introduced to the staff after that. She stated that her expectations were that when a new practice such as the EBP was introduced it would be implemented upon receipt. The former DON was not available for interview during the survey. An interview with the Administrator on 6/27/24 at 6:03 PM revealed that his expectation was that the EBP be implemented upon receipt. He stated that the breakdown was the former DON had not implemented the information she was given.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345432	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47683 Based on record review and staff interview the facility failed to include documentation in the medical record of refusal or acceptance of the influenza and pneumonia vaccinations for 1 of 5 residents (Resident #20) reviewed for immunizations. The findings included: Resident #20 was admitted to the facility on [DATE] with the quarterly minimum data set (MDS) dated [DATE] revealing she was cognitively intact. The MDS indicated Resident #20 did not receive the flu vaccination because Resident #20 received it from an outside location with no date noted. It was further documented that the pneumonia vaccination was not offered to Resident #20 and her pneumonia vaccination was not up to date. Record review of Resident #20's immunizations and consents revealed no available documentation regarding receiving, offering, refusing, or education for the flu or pneumonia vaccinations. An interview on 6/26/24 at 1:30 PM with Resident #20 revealed that she usually refused the flu shot every year but thought that she had agreed to the pneumonia shot this year. She stated that she could not remember though. An interview on 6/27/24 at 4:21PM with the Regional Nurse Consultant and Infection Preventionist revealed the breakdown with the consent forms for Resident #20 was the forms were lost in transition when the companies switched ownership in September 2023. She stated her expectations were that all vaccine consent be obtained upon admission for the residents and filed in the medical record. An interview with the Administrator on 6/27/24 at 6:03 PM revealed his expectation was for all resident vaccine consents to be obtained upon admission. He stated that the consent forms were lost during the company transitioned ownership in September 2023.