STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345475	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tsali Care Center	267 Tsali Care Way Cherokee, NC 28719

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21689 Based on observations, interview, record review, and review of the facility's Resident Rights, the facility failed to promote dignity by ensuring a resident was dressed for one (1) resident of 19 sample residents (Resident #112). The findings include: Resident #112 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis of acute pyelonephritis (kidney infection) and methicillin resistant Staphylococcus aureus (MRSA) infection. Review of the Minimum Data Set (MDS) dated [DATE] revealed the resident had severe cognitive impairment. During an observation and interview on 08/20/24 at 09:45 AM, Resident #112 was in bed with a cover pulled up to his chin. The resident stated he didn't have any clothes on because his clothes had gotten dirty. He stated he had clean shirts in his closet, but staff had not helped him get dressed and he would like to have clothes on. The resident pulled the cover down to show his shoulders and chest were bare. The resident stated all he was wearing was a pull up diaper. During an observation and interview on 08/20/24 at 10:10 AM, Certified Nurse Aide (CNA) #3 and #4 transferred Resident #112 to a shower chair to take him to the shower. The resident was not clothed and was only wearing an incontinence brief. CNA #3 stated the resident had an episode of incontinence before breakfast and she changed the resident's bed linens and left the resident undressed because she knew she would be taking him to the shower after breakfast. During an interview on 08/22/24 at 01:10 PM, the Director of Nursing (DON) confirmed the expectation was that residents would be dressed after incontinence episodes and not left undressed for breakfast. Review of the facility's undated Resident Rights, revealed, .As a resident of this facility, you have the right to a dignified existence .Quality of life is maintained or improved .A homelike environment, and use of personal belongings .Reasonable accommodation of needs and preferences .You have the right as a resident to receive services with reasonable accommodations to individual needs and preferences .You have the right to make choices about aspects of your life in the facility that are important to you .

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

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

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 39734 Based on the resident group interview, review of resident council meeting minutes, and staff interview, the facility failed to ensure grievances voiced in the group meeting were promptly acted upon and responded back to the resident group to address issues regarding cold food for six (6) of nine (9) residents who attended and participated in the group interview. The findings include: Review of the Resident Council Meeting Minutes from February 2024 through July 2024 revealed the resident council met on a regular basis and the Activity Director documented the meeting minutes and attendance. Concerns regarding food included the following: 07/30/24 - Food trays are still coming out late and cold - will follow up with dietary supervisor. 06/27/24 - Food trays are still coming out late and cold - will follow up with dietary supervisor. Residents are concerned about the food trays coming out late and cold. (Name of Dietary Manager) spoke with residents about staffing issues and why trays are late on the halls. 05/28/24 - Breakfast and lunch trays are late residents say at times. 04/25/24 - Residents are stating food is cold when is delivered to rooms at dinner time. A group interview was conducted on 08/21/24 at 1:30 PM. Six alert and oriented residents participated in the discussion (three additional residents did not participate but were present in the room.) Upon inquiry all six residents agreed that meals were frequently cold. Resident A stated that he thought it was because the meal carts sat out on the hall too long before meal trays were delivered. The residents agreed cold food was an issue on the halls not in the dining room. Resident B stated that his breakfast was consistently cold, and lunch was often cold as well. The residents all confirmed that they had expressed their concern about cold food in the group meeting before, but nothing changed, and no one came to let them know what the facility was going to do to fix the problem. During an interview on 08/22/24 at 3:25 PM with the Activity Director he stated that he used to send the minutes to the Administrator for follow-up but more recently he also sent the minutes to the Department Head responsible for the area of concern. In July he sent it to the Dietary Manager. He had not yet received any feedback on what was being done review and resolve the residents ongoing concern regarding cold food.

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35951 Based on medical record review, resident and staff interviews, and facility policy titled, Resident Funds Policy, the facility failed to ensure a quarterly statement was provided to one (1) of three (3) residents reviewed for personal funds (Resident #9). The findings include: Resident #9 was readmitted to the facility on [DATE]. The Minimum Data Set (MDS) completed on 07/16/24 revealed that the resident was cognitively intact. The MDS revealed that Resident #9 was the primary respondent. The resident's face sheet revealed Resident #9 was his own responsible party. The medical record did not reflect that Resident #9 had requested or appointed another representative to receive the personal fund statements, nor an appointed legal financial representative. During an interview on 08/20/24 at 10:34 AM, Resident #9 stated he did not receive a quarterly statement of his monies. During an interview on 08/22/24 at 12:56 PM, [NAME] Specialist #1 stated she had been in her role for two weeks and was still determining whether a quarterly statement was provided to Resident #9. During an interview on 08/22/24 at 2:05 PM, [NAME] Specialist #1 indicated she only had a sticky note stating that the resident's quarterly statement was hand-delivered without a delivery date or who delivered it. The sticky note was not provided for review. During an interview on 08/22/24 at 2:20 PM, Resident #9 confirmed he did not receive the quarterly statement dated June 30, 2024. The resident stated, I want to know how much money is in my account. How much is on that paper? During an interview on 08/22/24 at 4:10 PM, the Administrator stated she expected residents' quarterly statements to be provided to the resident and/or the resident's representative quarterly. A review of an email submitted by the Administrator on 08/23/24 revealed correspondence from the Social Worker (SW), to the administrator, reflecting that she recalled the resident received the trust statement for June 2024. The SW correspondence revealed, When addressing resident finances we always have a witness who accompanies the team. The medical/financial records at the time of the survey did not reflect that the resident received a quarterly statement. The policy dated 11/16/24 revealed, Resident Funds statements shall be sent out after the end of each quarter the bank statement as the bank statement delivery allows and in accordance with all applicable state and federal regulations. A copy of the statement shall be sent to: Responsible party receiving the resident's bill (unless otherwise, or it would be in the resident's best interest not to send it as determined by the Social Worker); Any resident requesting one; or Any resident deemed capable of understanding the statement per the resident's care plan.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21689 Based on record review and interview, the facility failed to provide residents an opportunity to formulate advanced directives for four (4) residents of 18 sample residents (Residents #33, #31, #112 and #9). The findings include: 1. Resident #33 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including non-ST elevation (NSTEMI) myocardial infarction (heart attack). Review of the Minimum Data Set (MDS) dated [DATE] revealed the resident was cognitively intact. Review of the Advance Directive and Code Status Acknowledgement of Receipt form in Resident #33's chart revealed Resident #33 signed the form 05/01/24 and marked I have chosen to formulate and issue Advance Directives. The resident indicated on the document that a Living Will and Do Not Resuscitate had been formulated. The form was signed by the Admission Coordinator on 05/01/24. Review of the electronic medical record and the resident's chart revealed there were no copies of a Living Will available. A Do Not Resuscitate Order was signed by a Nurse Practitioner with an effective date of 07/02/24. 2. Resident #31 was admitted to the facility on [DATE] with diagnosis including nondisplaced fracture of distal phalanx of right great toe. Review of the MDS dated [DATE] revealed the resident had severe cognitive impairment. Review of Resident #31's electronic medical record and the resident's chart revealed there were no advance directives, no Advance Directive and Code Status Acknowledgement of Receipt form, and no documentation the resident or the resident's representative was provided an opportunity to formulate advance directives. 3. Resident #112 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of Acute Pyelonephritis (kidney infection) and Methicillin Resistant Staphylococcus Aureus (MRSA) infection. Review of the MDS dated [DATE] revealed the resident had severe cognitive impairment. Review of the Advance Directive and Code Status Acknowledgement of Receipt form in Resident #112's chart revealed Resident #112 signed the form 04/09/24 with just his initials and nothing was marked on the form to indicate whether the resident had advance directives or wanted to the opportunity to formulate advance directives. The form was blank except for the resident's name, initials, and the signature of the Admission Coordinator on 04/09/24. Review of the electronic medical record and the resident's chart revealed there were no advance directives and no documentation the resident or the resident's representative was provided an opportunity to formulate advance directives. 4. Resident #9 was admitted [DATE] with diagnoses including Type 2 Diabetes Mellitus, Chronic Obstructive Pulmonary Disease and Heart Failure. Review of the Admission Record revealed the resident was his own Responsible Party. Review of the Minimum Data Set (MDS) dated [DATE] revealed the resident was cognitively intact. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #9's electronic medical record and the resident's chart revealed there were no advance directives, no Advance Directive and Code Status Acknowledgement of Receipt form, and no documentation the resident was provided an opportunity to formulate advance directives. During an interview on 08/22/24 at 08:57 AM, the Social Worker stated advance directives were the responsibility of the Admission Coordinator. She stated the Admission Coordinator asked about advance directives during the admission process and then followed up on any needed documentation or requirements. If on admission the resident wanted to formulate an advance directive, the Admission Coordinator would follow through with the resident or resident representative. During an interview on 08/22/24 at 12:58 PM, the Admission Coordinator stated during the admission process, she provided admission documents and application to the resident and/or resident representative for them to complete. She then placed the completed documents in the medical records including the Advance Directive and Code Status Acknowledgement of Receipt form. The Admission Coordinator stated that she had not been following up to ensure all documents were obtained and completed and no one had been ensuring that residents were provided an opportunity to formulate advance directives.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 41818 Based on interview, review of facility documents, and review of a facility policy entitled TCC Administrative - Advance Beneficiary Notices, Beneficiary Appeal Rights, and Expedited Review Policy, the facility failed to ensure residents were issued a Notice of Medicare Non-Coverage form for 12 of 12 residents (Resident #s 15, 20, 29, 32, 46, 51, 112, 259, 260, 261, 262, 263) who no longer qualified for Medicare part A and had days remaining. The findings include: During an interview on 08/22/24 at 12:41 PM, the [NAME] Specialist stated she started at the facility on 08/05/24. She stated since she began as [NAME] Specialist, she had not sent any NOMNC (Notice of Medicare Non-Coverage) notices. She stated she was not aware it was her responsibility to send out NOMNC notices and had no understanding of the NOMNC and who should have received them. During an interview on 08/22/24 at 01:13 PM, the Administrator stated the [NAME] Specialist was responsible for making sure NOMNC notices were sent out. She stated she was unaware NOMNCs were not being sent. She confirmed the above listed 12 residents should have received NOMNC forms, but had not. Review of the facility policy entitled TCC Administrative - Advance Beneficiary Notices, Beneficiary Appeal Rights, and Expedited Review Policy dated 6/4/2024 read, The NOMNC must be delivered at least two (2) calendar days before Medicare covered services end or the second to last day of service if care is not being provided daily. Providers must deliver the NOMNC to all beneficiaries eligible for the expedited determination process, even if the beneficiary agrees with the termination of services. The provider must ensure that the beneficiary or representative received the notice and understand that the termination an be disputed.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 39734 Based on observation and staff interview the facility failed to ensure a worn and soiled mattress was replaced and failed to ensure a soiled slipper pan was cleaned or replaced for one (1) of 22 sampled residents (Resident #14). The findings include: On 08/20/24 at 10:46 AM Resident #14's mattress was observed. There was an approximately 3 foot long by 2 foot wide worn discolored area on her mattress. The mattress was green, but the worn area was grey brown and appeared dirty. There was also a slipper pan in her bathroom that had brown matter residue inside the slipper pan. It was sitting on top of a package of briefs. Photographic evidence obtained. On 08/22/24 at 6:40 PM the Director of Nursing (DON) observed the photos of Resident #14's mattress and slipper pan and stated that the Certified Nursing Assistants should have reported the poor condition of the mattress, and it should have been changed out for a new one. She also stated that the slipper pan should have been discarded and replaced with a new one.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21689 Based on record review, interview, review of the facility's procedure entitled Instructions for Residents to Transfer to Hospital, and review of the facility's policy TCC Social Services - Transfers and Discharges Policy, the facility failed to ensure a resident received notification of the reason for transfer to the hospital for one (1) resident of three (3) sample residents (Resident #112). The findings include: Resident #112 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of acute pyelonephritis (kidney infection) and methicillin resistant Staphylococcus aureus (MRSA) infection. Review of the Minimum Data Set (MDS) dated [DATE] revealed the resident had severe cognitive impairment. Review of a Nurses Note dated 07/03/24 at 07:47 PM revealed, CNA [Certified Nurse Aide] staff reported to this nurse resident was not responding appropriately to them. Immediately assessed resident and resident was unable to speak, eyes were not reactive to light, resident unable to grip bilaterally, upper extremities flaccid, and respiration was shallow .Notified facility MD [physician] for order to send resident to ER [emergency room] for eval and tx [evaluation and treatment]. EMS [Emergency Medical Services] called and responded quickly. EMT [Emergency Medical Technician] assessed resident and stated suspected complete right side CVA [stroke]. Resident was air-lifted to [hospital] . Review Resident #112's electronic medical record indicated the resident returned to the facility on [DATE] with diagnoses of elevated ammonia levels and epilepsy and was started on medications to treat both. The resident had returned to his mental baseline. Review of a Nurses Noted dated 07/24/2024 at 11:00 AM revealed, Called to resident room by therapy d/t [due to] resident being minimally responsive and unable to follow simple commands .Pupils are equal and reactive. Order received to send resident to ER for evaluation . Review Resident #112's electronic medical record indicated the resident returned to the facility on [DATE] with a diagnosis of complicated urinary tract infection. Review of the electronic medical record and the resident's chart revealed no documentation Resident #112, or his representative were provided written notice of the reasons for transfer to the hospital on 07/03/24 and 07/24/2024. During an interview on 08/22/24 at 02:31 PM, the Medical Records clerk stated there were no copies of the hospital transfer documents in the electronic file. The Medical Records clerk confirmed nursing staff should be keeping copies as part of the medical record file. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interviews on 08/22/24 at 03:03 PM and 05:28 PM, the Administrator and the Director of Nursing provided a copy of the transfer packet to be completed when a resident transferred to the hospital. The forms included one dated 08/2019 entitled Nursing Home Notice of Transfer/Discharge. The form had a section entitled Reason(s) for Transfer/Discharge and options that included: It is necessary for your welfare and your needs cannot be met in this facility; Your health has improved sufficiently so that you no longer need the services provided by this facility; The safety of individuals in this facility is endangered due to the clinical or behavioral status of the resident; The health of individuals in this facility would otherwise be endangered; You have failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at this facility; or The facility ceases to operate . The form did not have an area to indicate a reason for a transfer to the hospital. The Administrator and DON stated they did not have a copy of the Nursing Home Notice of Transfer/Discharge form for Resident #112's hospitalization s and they did not have documentation the resident or the resident's representative was provided written notice of the transfers to the hospital on 07/03/24 and 07/24/24. Review of the facility's undated procedures entitled Instructions for Residents to Transfer to Hospital revealed, .Copy of the following paperwork to send with the resident .9. Transfer/Discharge Notice fill out and send a copy with resident . Review of the facility's policy TCC Social Services - Transfers and Discharges Policy dated 07/24/24, revealed, .All documentation concerning the transfer or discharge of the resident must be recorded in the resident's medical record .When a resident is transferred or discharged from a skilled nursing facility, the following forms should be used: The Nursing Home Notice of Transfer/Discharge .Documentation form the interdisciplinary care plan team concerning transfers or discharges for nursing facilities residents may include, but is not limited to: The reason(s) for the transfer or discharge .

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21689 Based on record review, interview, and review of the facility's procedure entitled Instructions for Residents to Transfer to Hospital, the facility failed to ensure a resident received notification of the facility's bed hold policy on transfer to the hospital for one (1) resident of three (3) sample residents (Resident #112). The findings include: Resident #112 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of acute pyelonephritis (kidney infection) and methicillin resistant Staphylococcus aureus (MRSA) infection. Review of the Minimum Data Set (MDS) dated [DATE] revealed the resident had severe cognitive impairment. Review of a Nurses Note dated 07/03/24 at 07:47 PM revealed, CNA [Certified Nurse Aide] staff reported to this nurse resident was not responding appropriately to them. Immediately assessed resident and resident was unable to speak, eyes were not reactive to light, resident unable to grip bilaterally, upper extremities flaccid, and respiration was shallow .Notified facility MD [physician] for order to send resident to ER [emergency room] for eval and tx [evaluation and treatment]. EMS [Emergency Medical Services] called and responded quickly. EMT [Emergency Medical Technician] assessed resident and stated suspected complete right side CVA [stroke]. Resident was air-lifted to [hospital] . Review Resident #112's electronic medical record indicated the resident returned to the facility on [DATE] with diagnoses of elevated ammonia levels and epilepsy and was started on medications to treat both. The resident had returned to his mental baseline. Review of the electronic medical record and the resident's chart revealed no documentation Resident #112, or his representative were provided written notice of the facility's bed hold policy. During an interview on 08/22/24 at 04:10 PM, the Administrator confirmed the facility did not provide a copy of the bed hold policy to the resident when transferred to the hospital on 07/03/24. Review of the facility's undated procedures entitled Instructions for Residents to Transfer to Hospital revealed, .Copy of the following paperwork to send with the resident .8. Send a copy of the Bed Hold Policy with resident to the hospital .

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39734 Based on staff interview and record review the facility failed to submit a referral for Level 2 PASSAR (Pre-Admission Screening and Resident Review) Evaluation for one (1) of one (1) resident (Resident #42) with an expired Level 2 PASSAR who remained in the facility. The findings include: Resident #42 was admitted [DATE] with diagnoses including major depressive disorder, recurrent, severe with psychotic symptoms; anxiety disorder; post-traumatic stress disorder; and type 2 diabetes mellites. He was admitted for orthopedic aftercare following surgical amputation. Review of the Admission Record revealed Resident #42 was admitted with a PASSAR Level 2 for short term admission which expired [DATE]. The most recent PASSAR Level 2 approval was also for short term admission and expired [DATE]. There was no evidence within the medical record to indicate the facility had submitted a referral for another Level 2 evaluation to extend approval past the [DATE] expiration date. During an interview with the Social Worker on [DATE] at 5:16 PM she confirmed Resident #42's PASSAR Level 2 had expired, and she had not submitted a request for another PASSAR Level 2 evaluation. She stated she was unaware that Level 2 approvals were sometimes only short term and had an expiration date.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21689 Based on record review, interview, observations, and review of the facility policy TCC Nursing Services - Safe Lifting and Moving of Residents Policy, the facility failed to revise the care plan for 1. falls interventions, and 2. after a change in condition for two (2) residents of 19 sample residents (Residents #51 and #112). The findings include: 1. Resident #51 was admitted to the facility on [DATE] with diagnoses of displaced intertrochanteric fracture of left femur and dementia. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severe cognitive impairment, was not ambulatory, required substantial/maximal assistance for transfers, and had a history of falls. Review of a Fall Risk assessment dated [DATE] for Resident #51 revealed a fall risk score of 12, with a score of 10 or greater indicating the resident was a high risk for falls. Review of an Incident Note dated 02/08/2024 at 06:58 PM revealed, The nurse was alerted to the dayroom by a CNA [Certified Nurse Aide]. Resident [#51] was found sitting on the floor in front of her wc [wheelchair], she appeared to have slipped out of her wc. Resident was assessed and assisted off the floor and back into her wc. Resident denied pain. Neuro checks initiated and the MD [physician] was notified of fall. No visible injuries noted. Resident sat at the nurse's station and had dinner there as well. Staff to continue to monitor; poc [plan of care] in place. Review of a post fall Fall Risk assessment dated [DATE] revealed a fall risk score of 12, indicating Resident #51 was a high risk for falls. Review of the MDS assessment dated [DATE] revealed Resident #51 had severe cognitive impairment, was not ambulatory, required partial/moderate assistance for transfers, and had one fall with no injury since the last assessment. Review of a quarterly Fall Risk assessment dated [DATE] revealed a fall risk score of 15, indicating Resident #51 was a high risk for falls. Review of an Incident Note dated 04/13/2024 at 07:59 AM revealed, Unwitnessed fall, no injuries. Resident was yelling help, writer and cna went running to her room. Resident was lying on her right side on the floor. Resident doesn't know where she was going. Resident denies hitting her head. Resident assisted to w/c and Neuro checks and Vitals started. POA [Power of Attorney], Administrator and Nurse Manager notified. Resident is up in w/c by nurses station. Review of a post fall Fall Risk assessment completed on 04/13/24, revealed a fall risk score of 18, indicating Resident #51 was a high risk for falls. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the care plan for Resident #51 created on 12/21/23 and revised 06/12/24 revealed the resident was at risk for falls with a history of a fall at home resulting in a left hip fracture with repair, and dementia. Falls interventions were implemented on 12/21/23 and 01/25/24. Review of the care plan revealed it was not updated to address the falls on 02/08/24 and 04/13/24 or with interventions to prevent further falls after those falls. During an interview on 08/22/24 at 02:35 PM, the MDS Coordinator confirmed the care plan for Resident #51 was not updated to address the falls or interventions to prevent further falls after the falls on 02/08/24 and 04/13/24. 2. Resident #112 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of acute pyelonephritis (kidney infection) and methicillin resistant Staphylococcus aureus (MRSA) infection. Review of the significant change MDS assessment dated [DATE] revealed the resident had severe cognitive impairment. Functional ability for sit to stand, chair/bed-to-chair transfer, and toilet transfer was not assessed due to the resident's medical condition or safety concerns. Resident #112 was dependent for tub/shower transfer. Review of Resident #112's care plan last revised 07/22/24 revealed the resident required assistance of one (1) person for transfers and the resident had a history of a fall at home before admission to the facility. Review of an Incident Note dated 8/17/24 at 10:16 AM revealed, Roommate came to desk to report that patient [Resident #112] is in the floor. Patient found by nurse and CNA sitting in floor, leaning against the wall. Assessment completed. Denies pain or injury. No marks or redness to skin. Small skin tear to right elbow cleaned with wound cleanser, TAO [a wound dressing] applied, covered with band aid. Assisted patient to bed, he states he was attempting to open the blinds, using the W/C to steady himself. The W/C rolled backwards, and he lost his balance . Review of an Occupational Therapy Plan of Care for Resident #112 dated 08/20/24 revealed treatment diagnoses of pain right shoulder and unsteadiness on feet. The reason for the referral was .last hospitalized for brainstem stroke was recovering well until sustaining a fall a few days ago with significant decline in function, mobility and ADL [activities of daily living] status and onset of R [right] shoulder pain. Skilled OT [Occupational Therapy] required to facilitate return to prior LOF [level of function] . Observation on 08/20/24 at 10:10 AM, revealed CNA #3 and #4 were in Resident #112's room transferring the resident to a shower chair. Each CNA had the resident underneath his arms, supporting him by his armpits, and physically pulling him up onto the shower chair. CNA #3 stated they did not normally have to physically transfer Resident #112 in that manner, but the resident was complaining that his right arm hurt and he couldn't move it. During an interview on 08/20/24 at 10:24 AM, Licensed Practical Nurse (LPN) #1 stated that it was not unusual for Resident #112's abilities to fluctuate and sometimes he was able to stand and walk and sometimes he was less physically able to assist with transfers. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/22/24 at 10:05 AM, the MDS Coordinator confirmed a significant change assessment was completed when Resident #112 returned from the hospital. She stated no one had communicated that Resident #112 ever required two (2) people to transfer the resident and that the care plan needed to be revised. When asked about the way the resident was transferred to the shower chair, she stated, That's not good. Review of the facility's undated policy TCC Nursing Services - Safe Lifting and Moving of Residents Policy, revealed, .The purpose of this Policy is to provide Tsali Care Center (TCC) teammates with guidelines for the safe lifting and moving of residents .This Policy applies to all: TCC Nursing staff (teammates) .TCC has instituted a safe resident lifting program that incorporates mechanical lift devices, appropriate techniques, and ongoing resident assessment, and teammate education to protect residents and teammates from injury and to improve quality of care .Nursing teammates .will assess the individual resident's needs for transfer assistance on an ongoing basis, including during the care plan process and with any significant change in condition. Resident transferring and lifting needs will be documented in the care plan .Manual lifting of residents will be eliminated when feasible .the safest manner to move the resident will assessed and utilized. This may include a gait belt and additional teammate support, such as using two (2) or more teammates to assist .

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35951 Based on observations, medical record review, staff, resident and physician interviews, and facility policy titled Pain Management Protocol Policy, the facility failed to manage pain for one (1) of five (5) residents (Resident #159). The findings include: Resident #159 was admitted to the facility on [DATE]. The resident's diagnoses included hemiplegia, personal history of transient ischemic attack (TIA), cerebral infarction without residual deficits, anxiety disorder, depression, adjustment disorder with mixed anxiety and depressed mood, psychoactive substance, other psychoactive substance dependence, and disorder of the kidney and ureter. A review of the Minimum Data Set (MDS) revealed that the MDS was in progress. A review of the care plan-focused concern revealed, I have/or am at risk for pain r/t (related to) dx (diagnoses) of neuropathy, decreased mobility. Interventions reflected Give medications as ordered by the physician. Monitor/document side effects and effectiveness. Focused concern also included I have/or am at risk for pain r/t dx of neuropathy, decreased mobility, Interventions revealed Administer analgesia as per orders .Anticipate the resident's need for pain relief and respond immediately to any complaint of pain . Evaluate the effectiveness of pain interventions after administration. Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition .Monitor/document for side effects of pain medication. Observe for constipation; new onset or increased agitation, restlessness, confusion, hallucinations, dysphoria; nausea; vomiting; dizziness and falls. Report occurrences to the physician .Monitor/record/report to Nurse resident complaints of pain or requests for pain treatment .Notify physician if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain .Observe and report changes in usual routine, sleep patterns, decrease in functional abilities, decrease ROM, withdrawal or resistance to care . A review of the admission pain assessment completed on 08/15/24 revealed Resident #159 had pain present within the last five days; pain frequency almost constant; pain effect on sleep almost constant; pain interference with therapy activities almost constant; limited day-to-day activities almost constant; and pain intensity on a numeric rating scale from 00-10 with pain of 9. A review of a pain assessment completed on 08/20/24 revealed Resident #159 had pain present within the last five days; pain frequency frequently; pain effect on sleep frequently; pain interference with therapy activities rarely or not at all; pain limited day-to-day activities rarely or not at all; pain intensity on a numeric rating scale from 00-10 with pain of three (3). A review of a pain assessment in the electronic health record with an effective date of 08/21/24 revealed a pain assessment; however, the assessment was blank. On 08/21/24 at 10:36 AM, LPN #1 confirmed that the pain assessment needed to be completed, signed, and dated. LPN #1 was uncertain why the pain assessment was not completed. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	A review of the medication administration record (MAR) revealed that Tylenol 325 mg (milligrams), two (2) tablets as needed for pain, or Tylenol 650 mg suppository for mild pain was not administered to the resident and/or any refusals for pain management noted. The MAR further revealed a discontinued order for Hydro/apap (combination pain medication including opioid) 5-325 mg, one (1) tablet twice daily as needed for pain for three (3) days, with an order date of 08/14/24 and a stop date of 08/16/24. The MAR reflected that no medications were administered or the resident refused. Further review of the MAR revealed Hydro/apap 5-325 mg, one tablet by mouth twice daily as needed for pain for three (3) days with an order date of 08/16/24 and a stop date of 08/19/24. The MAR reflected no medications were administered or the resident refused. A review of the narcotic sheet revealed prescription #2167268 (Hydro/apap 5-325 mg), a quantity of six (6) pills, was sent from the pharmacy. The medications were noted received on 08/15/24. The narcotic sheet reflected six (6) pills were sent back to the pharmacy on 08/20/24 due to discontinued. The document did not reflect that the resident received any pain management medications. The narcotic sheet reflected that one (1) tablet was wasted on 08/16/24 at 0025 (12:25 AM) and one (1) tablet was wasted on 08/20/24 at 2130 (9:30 PM). A review of the narcotic sheet revealed that prescription #2167325 (Hydro/apap 5-325 mg) contained six (6) pills sent from the pharmacy. The medications were noted received on 08/17/24. The narcotic sheet reflected that six (6) pills were sent back to the pharmacy on 08/20/24 due to discontinuation. The document did not reflect that the resident received any pain management medications. A review of the MAR reflected that Gabapentin 300 mg, one capsule, was administered three times daily for neuropathy. During an interview on 08/20/24 at 10:44 AM, Resident #159 stated that he was in pain eight (8) out of 10 on his right side. He stated he had not received anything for pain, nor had he notified the primary nurse (LPN #1) or Medication Aide (MA) #1. Upon departing the resident's room, MA #1 was in the process of a medication pass and notified of the resident's complaint of pain. During an interview on 08/20/24 at 2:20 PM, LPN #1 stated, Usually, the medication aide will inform me if a resident complains of pain. Once notified by the medication aide, I will assess the resident. LPN #1 acknowledged that she was aware that the resident complained of right-side pain today, and the resident had informed her that Tylenol would not work for the pain he was having. She further shared that labs were drawn last night. LPN #1 concluded that she notified the medical director (MD) regarding the resident's pain via tiger text and was awaiting a response. On 08/21/24 at 9:20 AM, the Physical Therapy Assistant (PTA) #1 was observed in the resident's room by his bedside. The PTA confirmed she was providing stretching exercises to the resident's lower extremities. The PTA was positioned on the resident's right side/lower extremities. The resident stated that he was having pain eight (8) out of 10 all over. The PTA continued with the stretching exercises. During an interview on 08/21/24 at 9:30 AM, LPN #2 confirmed that she had not been made aware of any complaints of pain from Resident #159. She stated that the medication aide was responsible for assessing, identifying, and documenting any pain medications administered and their effectiveness. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	During an interview on 08/21/24 at 9:33 AM, LPN #1 indicated the MD responded via tiger text on 08/20/24 at 3:28 PM with new orders for pain management that included Lidocaine patch 5% every 12 hours as needed for pain and Diclofenac gel two grams 1% twice daily as needed to the affected area for pain. LPN #1 indicated she did not provide education to the resident regarding how the medication worked in managing pain because the resident stated he already knew how the medications worked. LPN #1 elaborated that the resident refused the medications because he wanted Hydrocodone. Additionally, LPN #1 confirmed that she did not initially transcribe the physician's order because the resident refused, nor did she document the resident's refusal of the medication in the medical record. During an interview on 08/21/24 at 9:36 AM, MA #2 confirmed she did not inquire from the resident regarding any pain or administer any pain medications before his therapy session. MA #2 stated the PTA notified her that the resident was having pain after the treatment session was completed. During an interview on 08/21/24 at 10:09 AM, the PTA stated she assumed Resident #159 received pain medication before the therapy session. The PTA indicated she did not inquire from the resident's medication aide or primary nurse if pain medications were administered before the start of the therapy session. The PTA explained Resident #159's therapy session included low load long duration manual stretching with Joint mob. The PTA stated the therapy treatment session lasted 30 minutes and included 15 minutes of stretching alternating with 15 minutes of joint mob. The PTA explained that joint mob helps with joint stiffness and allows for more movement. The PTA elaborated that she used hot packs during the therapy session to assist with the resident's pain. The PTA concluded that Resident #159 complained of pain ranging from eight (8) to 10 during the 30-minute treatment session. During an interview on 08/21/24 at 11:03 AM, Resident #159 stated, They will not give me anything for pain. My pain is eight (8) out of 10, and my right side constantly ached all day yesterday. The resident stated that during his therapy treatment session this morning, his pain was 10 out of 10 in his feet during the exercises, and he informed the therapist. He concluded that he was not aware or informed of an order for the Lidocaine patch and would consider wearing the patch to help with his pain; however, he would like to know why he cannot have Hydrocodone. During an interview on 08/21/24 at 11:19 AM, LPN #1 was made aware of Resident #159's interview related to the Lidocaine patch and that he said he would consider the patch to help alleviate his pain; however, he would like to know the status of the Hydrocodone he had previously. During an interview on 08/22/24 at 5:37 PM, the Director of Nursing (DON), accompanied by the Administrator, the DON stated if therapy enters a resident's room and the resident complains of pain, the concern should be immediately reported to the resident's nurse. The DON added that the MA should be notified if the nurse was unavailable. The DON explained that the MA must get permission from the licensed or registered nurse before administering pain medication to residents. The DON elaborated that if a nurse is unavailable, the MA is expected to notify the on-call supervisor. The DON explained that it is the responsibility of the licensed or registered nurse to assess and evaluate pain medication effectiveness after administration. The DON stated that the resident's refusal of medication should be documented in the medical record (MAR), a progress note reflecting why the resident refused the medication and any education provided to the resident on why the medication is important. The DON confirmed that the initial physician order for the Lidocaine patch was on 08/20/24 and was not added to the MAR until 08/21/24. The DON reviewed the medical record and acknowledged that pain was a concern for Resident #159. The DON confirmed that Resident #159 did not receive any of the medication (hydro/apap 325 mg) during the time frame ordered for pain management. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	During an interview on 08/22/24 at 7:09 PM, the MD explained that upon admission, she copied the resident's discharge orders and extended the hydro/apap 325 mg as needed for pain management to monitor and track during the trial period. She acknowledged the medication was available for the resident's use while ordered. The MD stated that Resident #159 was experiencing post-stroke pain, which was not an indicator of treatment with opioids. She stated that the goal was to try other alternatives. The MD indicated Resident #159 was having neuropathic pain and take gabapentin three times daily. The MD concluded she would look at other options after a review of the medical record to determine the best approach to manage the resident's pain moving forward and that Resident #159 had a history of strokes. The policy dated 03/26/24 read, Documentation and Reporting: 1. Nursing teammates should document the pain assessment and the resident's reported level of pain with adequate detail (i.e., enough information to gauze the status of pain and the effectiveness on interventions for pain) as necessary and in accordance with the pain management program. 2. Nursing teammates should report the following information to the Provider: significant changes in the level of the resident's pain; Prolonged, unrelieved pain despite care plan interventions.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21689 Based on record review, interview, observations, and review of staff training, the facility failed to ensure Certified Nurse Aides were competent to report changes in condition to the nurse for one (1) resident of 19 sample residents (Resident #112). The findings include: Resident #112 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of acute pyelonephritis (kidney infection) and methicillin resistant Staphylococcus aureus (MRSA) infection. Review of the significant change MDS assessment dated [DATE] revealed the resident had severe cognitive impairment. Functional ability for sit to stand, chair/bed-to-chair transfer, and toilet transfer was not assessed due to the resident's medical condition or safety concerns. Resident #122 was dependent for tub/shower transfer. Review of Resident #112's care plan last revised 07/22/24 revealed the resident required assistance of one (1) person for transfers. During an observation and interview on 08/20/24 at 09:45 AM, Resident #112 stated that his right arm and shoulder was hurting this morning and that he could not move his arm or use it. During an observation on 08/20/24 at 10:10 AM, Certified Nurse Aide (CNA) #3 and #4 were in Resident #112's room transferring the resident to a shower chair. The CNA's confirmed Resident #112 was complaining that his right arm hurt, and he couldn't move it and CNA #3 confirmed he had complained of the right sided pain that morning before breakfast. During an observation and interview on 08/20/24 at 10:14 AM, Occupational Therapist (OT) #2 had entered Resident #112's room, talked with him briefly and then exited the room. OT #2 stated she was going to do an evaluation on the resident for a recent decline, but the resident was stating that he could not move his right arm and it hurt, and she was looking for the Director of Rehab and the nurse to report the condition and inquire about obtaining an x-ray. During an interview on 08/20/24 at 10:24 AM, Licensed Practical Nurse (LPN) #1 stated that no one had reported to her that Resident #112 had a change in condition and was reporting arm pain. She stated he did have a fall a few days ago and she would call the physician to get an x-ray. During an interview on 08/21/24 at 09:26 AM, LPN #1 stated the results from the x-ray were normal, but Resident #112 was still unable to move his arm and shoulder. During an interview on 08/22/24 at 12:52 PM, the Director of Nursing stated CNAs were trained in orientation to report any resident changes in condition to the nurse immediately. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of training records revealed CNA #4 had received orientation training, including Chain of Command and Incident/Accident Reporting Process, and had been checked as competent on skills, competency, policy, and procedures 05/01/24 and 05/07/24. CNA #3 was the employee who evaluated CNA #4's competencies. The facility was not able to provide complete training records for CNA #3 and there was no documentation of her orientation training, date of hire, or education on reporting changes in condition.

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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. 39734 Based on staff and Medical Director interview, record review, and review of facility policy the facility failed to 1) ensure medication was available as ordered for two (2) of five (5) residents (Resident #s 14 and 9) reviewed for unnecessary medications and failed to 2) ensure a staff member followed facility policy to sign off the controlled count sheet immediately after dispensing a controlled medication for one (1) of two (2) staff observed dispensing controlled medication. The findings include: 1) Review of the August 2024 Medication Administration Record for Resident #14 revealed the resident's Duloxetine DR 20 mg (milligram) capsules twice daily for anxiety was documented as not given due to waiting on pharmacy, three (3) evenings in a row on August 13th, 14th and 15th. Review of the August 2024 Medication Administration Record for Resident #9 revealed the resident's Xifaxan 550 mg 1 tablet twice daily for liver disease was documented as not given due to meds not available from pharmacy, or waiting on pharmacy, or on order on 5 evenings August 1st, 2nd and 3rd and August 17th and 18th. During an interview with the Director of Nursing (DON) on 08/22/24 at 6:05 PM, she was unaware there had been a supply issue with either Resident #14's Duloxetine or Resident #9's Xifaxan. She stated that the facility received pharmacy deliveries twice a day so if the medication was on order, it should not have taken so long to come in. She stated that the last row on the medication punch card was blue and when the supply got to that point staff were supposed to reorder the medication. Once reordered other staff could see this had been done. The DON stated she expected staff to let her know they were having difficulty getting these medications timely. She also stated it was concerning that only the evening dose documentation indicated the medication wasn't available, in the above examples, and she would need to research to find out if the medication was being documented as given when it wasn't given, if it was obtained from the emergency supply, or if there was some other explanation for the discrepancy. During an interview with the Physician/ Medical Director on 08/22/24 at 7:30 PM she stated that the Pharmacy should have informed her if they were having difficulty with the supply of these two medications. She also stated that for Resident #9 not having the Xifaxan for several days was not a significant error and she had been considering discontinuing the medication. For Resident #14 she stated that due to the resident's anxiety not having the Duloxetine for several days was concerning. 2) During an observation of a medication pass on 08/21/24 at 9:17 AM, Medication Aide (MA) #1 was observed dispensing two controlled drugs for Resident #14: Clonazepam 0.5 mg and Oxycodone 5 mg (1/2 tablet). MA #1 did not document (sign out) the medication on the declining inventory sheet. On 8/21/24 at 10:45 PM, MA #1 confirmed she had not completed the declining inventory sheet for either of the controlled medications she administered to Resident #14. She acknowledged the sheet was to be filled in when the medication was dispensed from the punch card. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/22/24 at 6:05 PM, the Director of Nursing (DON) said she expected staff to complete the declining inventory sheet right after dispensing controlled medications to ensure the count was correct. Review of the 07/16/24 facility policy titled Controlled Medication Administration Policy read, When a controlled medication is removed from its card or container to be administered, the authorized staff member (licensed nurse or medication technician in assisted living facilities) administering the medication immediately enters the following information on the declining inventory sheet: date and time of administration, amount administered, signature of the authorized staff member administering the dose, completed after the medication is administered.

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Tsali Care Center	267 Tsali Care Way Cherokee, NC 28719

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 39734 Based on observation, staff interview and review of facility policy the facility failed to ensure the medication error rate was below 5%. There were five (5) medication errors out of 31 opportunities for a medication error rate of 16.13%. The findings include: On 08/19/24 at 4:45 PM Licensed Practical Nurse ((LPN) #3 was observed administering 12 units of LISPRO Insulin to Resident #49 using an insulin pen. LPN #3 did not prime the insulin pen prior to administration. On 08/19/24 at 5:00 PM Registered Nurse (RN) #3 was observed administering 22 units of FIASP Insulin to Resident #4 using an insulin pen. RN #3 did not prime the insulin pen prior to administration. During an interview on 08/19/24 at 5:58 PM LPN #3 confirmed she just dialed up the 12 units of insulin and administered the insulin. She confirmed she did not prime the insulin pen and stated that she was not aware it needed to be primed. During an interview on 08/19/24 at 6:10 PM RN #3 confirmed she dialed up the 22 units of insulin and administered the insulin without priming the insulin pen. She confirmend that she was aware the insulin pen should have been primed and the resident would not have gotten the full ordered dose without priming. On 08/21/24 at 9:17 AM Medication Aide (MA) #1 was observed administering Erythromycin Eye Ointment and Refresh Eye drops to Resident #14. The Eye ointment was administered incorrectly. Instead of using one hand to pull down on the resident's right lower lid to administer a ribbon of ointment along the resident's lower lid MA #1 administered a drop of ointment. MA #1 did not administer Refresh eye drops in the resident's right eye and administered two drops in the resident's left eye. Review of the physician orders for Resident #14 revealed: Erythromycin 0.5% eye ointment, apply ribbon to right eyelid three times a day. Refresh tears 0.5% place one drop into each eye twice daily. During an interview with the Director of Nursing (DON) on 08/22/24 at 1:05 PM she confirmed that the erythromycin eye ointment should have been administered as a ribbon along the resident's lower eye lid. She also stated that the Refresh tears should have been administered to the resident's right eye, they just needed to be administered first and then after 5 minutes the eye ointment could be administered. In addition, she said that the refresh tears should have been administered as ordered; one drop should have been given not two. The DON also confimred that insulin pens needed to be primed and if they weren't the resident would not receive the full dose of insulin as prescribed.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 39734 Based on observation, staff interview, and review of the manufacturer's Prescribing Information the facility failed to ensure in-use insulin was dated when opened and dated with an accurate Do Not Use After date, and failed to ensure an inhaler medication was dated when opened for one (1) of three (3) medication carts (Hall D). The findings include: On 8/19/24 at 4:30 PM Licensed Practical Nurse (LPN) #3 was observed opening a new LISPRO Insulin Pen for Resident #49. LPN #3 wrote the opened date as 08/19/24 and the Do Not Use After date as 10/18/24 (60 days after opened date). During an interview on 08/19/24 at 5:48 PM LPN #3 confirmed she had documented the discard date for Resident #49's LISPRO Insulin Pen as 60 days after opening because she thought that was how long it could still be used after opening. After looking up the information she confirmed 60 days was not correct and the opened LISPRO could only be used for 28 days. She revised the Do Not Use After date to 9/16/24 (28 days). An observation of the Hall D medication cart on 08/19/24 at 6:07 PM, with LPN #3 present, revealed an opened LANTUS Insulin Pen for Resident #9 that was not dated when opened and did not have a Do Not Use After date. An observation of the Hall D medication cart on 08/21/24 at 9:17 AM, with Medication Aide (MA) #1 present, revealed an opened ADVAIR DISKUS for Resident #14 that was not dated when opened. MA #1 confirmed ADVAIR DISCUS was supposed to be dated when it was opened because it had to be discarded 30 days after opening. During an interview on 08/22/24 at 1:05 PM, the Director of Nursing (DON) confirmed she expected staff to date ADVAIR DISKUS and Insulin pens when opened and to write the accurate discard date on each opened insulin pen. Review of the Manufacturer's Prescribing Information for HUMALOG (LISPRO) dated 08/2023 revealed, Opened HUMALOG vials, prefilled pens, and cartridges must be thrown away 28 days after first use, even if they still contain insulin. When stored at room temperature HUMALOG Can only be used for a total of 28 days, including both not in-use (unopened) and in use (opened) storge time. Unopened HUMALOG should be stored in a refrigerator and can be used until the expiration date . Review of the Manufacturer's Prescribing information for LANTUS dated June 2023 revealed, when not in use (unopened) the prefilled insulin pens could be refrigerated until the expiration date or kept for 28 days at room temperature. In use (opened) pens could be kept either refrigerated or at room temperature for 28 days and but then must be discarded. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Manufacturer's Prescribing Information for ADVAIR DISKUS dated June 2023 revealed, Discard ADVAIR DISKUS 1 month after opening the foil pouch or when the counter reads '0' (after all blisters have been used), whichever comes first.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 39734 Based on staff interview and review of the Facility Assessment the facility failed to ensure the required parties were involved in developing the Facility Assessment, failed to ensure the staffing plan was provided per unit as required, failed to address resources necessary to grandfather residents who smoke, and did not clearly state staff competencies and required training, which had the potential to affect 56 of 56 residents. The findings include: Review of the Facility Assessment revealed it was revised 4/1/24 and updated 7/25/24. The persons involved in completing the assessment were listed as the Administrator, the Director of Nursing (DON), the Medical Director and a Governing Board Member. There was no indication that direct care staff were involved in completing the assessment or that the facility solicited and considered input from residents, resident representatives and family members. Further review revealed that the staffing plan listed the number of Floor Nurses (Registered Nurse or Licensed Practical Nurse), Medication Aides, Certified Nursing Assistants (CNAs) and Restorative CNAs the facility planned to have daily on average. However, the staffing plan did not address staffing needs for each unit of the facility or for each shift and weekends, or address staffing needs in these areas based on changes to the resident population as required. In addition, the facility was a previous smoking facility with residents that were grandfathered for smoking however the resources needed to accommodate smoking for the grandfathered residents were not included in the facility assessment. Regarding annual education, orientation checklists and competency the Facility Assessment read, The annual education calendar and orientation checklists can be found at the following with the SDC (Staff Development Coordinator). The CNA competency checklists for the electronic medical record can be found at: The nurse competency checklists for the electronic medical record can be found at the SDC {sic}. The new hire and annual skills checklists for nursing staff can be found with SDC. These lists were not provided. During an interview with the Administrator on 08/22/24 at 6:27 PM she stated that she was unaware the requirements for the Facility Assessment had changed. She also stated that the leadership did not know if the residents who smoked would need to be grandfathered for smoking in the new facility but now that they knew they would plan for those residents to still be able to smoke. In addition, she stated that the facility was working on streamlining staff training as the online education selections had been more oriented towards hospital staff.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35951 Based on observation, medical record review, staff interviews, and facility policy titled Enhanced Barrier Precautions, the facility failed to 1) implement Enhanced Barrier Precautions (EBP) for one (1) of one (1) resident admitted with a pressure ulcer (Resident #31); and failed to 2) ensure a single resident use glucometer was cleaned and disinfected according to facility policy and the sanitizing wipes manufacturers instructions for one (1) of two (2) residents (Resident #49). The findings include: 1. Resident #31 was admitted to the facility on [DATE]. The resident's diagnoses included pressure ulcers. The Minimum Data Set (MDS) completed on 08/01/24 revealed Resident #31 was admitted with one (1) stage 2 and one (1) stage 3 pressure ulcer. The MDS reflected that the resident had one (1) unstageable pressure ulcer with slough and/or eschar and one (1) unstageable pressure ulcer with suspected deep tissue injury in evolution present on admission. The MDS Care Area Assessment revealed that pressure ulcers were triggered care areas of concern. A review of the facility resident matrix printed on 08/19/24 revealed that Resident #31 was identified with an unstageable pressure ulcer. On 08/22/24 at 12:49 PM, Resident #31 was lying in the bed. No EBP signage or personal protective equipment (PPE) was on the resident's door or wall entry to the room. During an interview on 08/22/24 at 3:36 PM, the Infection Control Preventionist (ICP) reviewed the medical record for Resident #31 and confirmed that the resident had a pressure ulcer. The ICP stated that the resident had not been on EBP since admission. During an interview on 08/22/24 at 6:42 PM, the ICP shared that she discussed with Registered Nurse (RN) #2 (wound nurse), and it was determined the facility had no documentation from the previous skilled nursing home as to why the resident had not been put on EBP. The ICP confirmed that the resident had two (2) pressure ulcers. The ICP confirmed that the resident had resided in the facility since July 25, 2024. The ICP confirmed upon reviewing the medical record that she did not see communication where the facility reached out to the previous facility to obtain information on whether the resident's pressure ulcers were chronic or newly developed. The policy revised 4/18/2024 read, Enhanced barrier precautions require the use of gowns and gloves for certain residents during specific high-contact resident care activities that provide opportunity for transfer of MDROs (Multi-Drug Resistant Organisms) to staff hands and clothing .Examples of high-contact resident care activities requiring gown and glove use include: wound care: any chronic wound requiring a dressing change .Implementation: 1. Staff will be educated on Enhanced Barrier Precautions by the Infection Control Preventionists or designee prior to implementation of precautions. 2. Post clear signage on the door or wall outside of the resident room indicating the type of precautions in place and required PPE (personal protective equipment). For Enhanced Barrier Precautions, signage should also indicate the high-contact resident activities that require the use of gloves and gowns . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	39734 On 08/19/24 at 4:45 pm, Licensed Practical Nurse #3 was observed using a single-resident use glucometer to test Resident #49's blood glucose. Prior to using the glucometer, she used a sanitizing wipe (CAVI brand) to wipe off the glucometer for approximately one (1) minute. After using the glucometer, she removed her gloves and used a sanitizer wipe for approximately one (1) minute to wipe the glucometer. She then placed the glucometer in a clean plastic cup. The front of the sanitizer wipe container had an indicator for a three (3)-minute contact time. Review of the directions on the sanitizer wipes (CAVI brand) with LPN #3 revealed the following: to disinfect and kill blood borne pathogens a three (3)-minute wet contact time was required. The instructions indicated the user should use one wipe to clean the glucometer and then use a second wipe and additional wipes as needed to maintain three (3) minutes of wet contact time. On 08/19/24 at 5:53 PM LPN #3 stated she thought the contact time was supposed to be one (1) minute but just realized she had the wrong sanitizer wipes on the insulin cart, she was supposed to be using the sanitizer wipes that had a one (1)-minute contact time (CAVI brand). Review of the Procedure Checklist Checking Fingerstick (Capillary) Blood Glucose Levels competency checkoff for LPN #3 dated 5/17/24 revealed the 1-minute contact time sanitizer wipes were to be used for cleaning and disinfecting the glucometers. The brand of wipes was not specified on the checklist. During an interview with the Director of Nursing on 08/22/24 at 1:59 PM she confirmed LPN #3 should have cleaned and disinfected the glucometer with the one (1)-minute sanitizer wipes and if using another type the instructions should be followed.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. 21689 Based on observations, interview, review of the dish machine operation manual, review of dish machine temperature logs, review of work orders, and review of the facility's policy TCC Dining Services - Warewashing - Dish Machine Policy, the facility failed to ensure the dish machine in the dietary department had a functioning wash temperature gauge which affected 56 of 56 residents in the facility. The findings include: During an observation and interview in the dietary department on 08/21/24 at 9:40 AM, the dish machine had two gauges, one for the wash cycle and one for the rinse cycle. The wash cycle gauge had a minimum required temperature of 150 degrees Fahrenheit (F) stamped under the dial. The kitchen staff ran a rack of dishes through the dish machine and the wash temperature read 146 F on the gauge. The staff ran a second rack of dishes through the washer, and the wash temperature on the gauge read 144 F. The Assistant Dietary Manager (ADM) confirmed the instructions on the machine indicated the wash temperature was to be 150 F minimum and stated the wash temperature never reached 150 F. She stated the machine had been serviced in the past for not reaching the minimum wash temperature. During an observation and interview on 08/21/24 at 10:11 AM, the ADM stated maintenance had looked at the dish machine and determined the wash gauge was not correctly registering the temperature. The staff had obtained temperature strips and ran another wash cycle and the temperature registered greater than 160 F. The staff then ran another cycle at that time and the machine achieved a temperature greater than 160 F, per the temperature strip. The ADM confirmed staff had not been using the temperature strips until now to determine the accurate temperature of the wash machine and had been documenting the gauge temperature on the temperature logs. During an interview on 08/21/24 at 02:53 PM, the Maintenance Director stated he had not been informed the dish machine was not registering the minimum 150 F on the wash gauge until this morning after the observation and interview with the ADM. The only time he was aware the gauge was faulty was in January when the gauge had been replaced by the service company. Review of the Installation/Operation Manual for the dish machine with an issue date of 09/07/22, revealed the machine was a high temperature dishwasher. The instructions indicated the wash cycle ran for approximately 40 seconds at a minimum wash temperature of 150 F. Required daily maintenance included checking the temperature gauges and displays to ensure they were operating correctly. Review of the dish machine temperature logs from February 2024 to August 2024 revealed the documented wash temperature reached the minimum 150 F on the following days: 152 F on 02/11/24, dinner; 150 F on 2/15/24, dinner; 152 F on 02/16/24, dinner; 150 F on 05/10/24, breakfast and lunch; 150 F on 05/06/24, dinner; and 150 F on 05/12/24, dinner. For all other days February through August 2024, the dish machine wash temperature did not meet the minimum 150 F. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of work orders for the dish machine revealed a work order dated 01/04/24 for a problem of the machine only reaching 120 F for the wash cycle. The machine was repaired on 01/11/24 by replacing a faulty thermostat, hoses, and rebuilding the solenoid valve and vacuum breaker. The machine was verified as reaching the minimum temperature. On 01/22/24, the wash temperature gauge was not working. A new gauge was ordered and replaced on 01/31/24. Review of the facility's policy TCC Dining Services - Warewashing - Dish Machine Policy, dated 03/22/24, revealed, .Dishware and service ware are cleaned and sanitized in a manner to prevent foodborne illness . Check for appropriate temperature, detergent, and sanitizer. 2. The Dishwashing Temperature Sanitizer Record or a similar form may be used to record and document temperatures and ppm [parts per million] prior to ware washing. The following are specifications for each method: High Temperature Dishwasher (heat sanitation): Wash 150 - 165 F .