STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. Building B. Wing	06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saturn Nursing & Rehabilitation	1930 West Sugar Creek Road Charlotte, NC 28262

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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** 20934 Based on observations, record review, and interviews with residents (Resident #88), family (Resident #74 and Resident #16), and staff, the facility failed to provide a dignified dining experience when three (3) residents who dined on the south unit did not receive assistance with their meal to allow them to eat with other residents who ate or were assisted to eat by staff. Resident #74 waited for staff to assist him with eating his meal, while his roommate, Resident #55 fed himself. Resident #88 and Resident #16 waited for staff to assist them with their meals while residents dining with them were assisted to eat by staff or fed themselves. This failure occurred for 3 of 3 residents sampled for dignity with dining (Residents #74, #88 and #16). The reasonable person concept was applied as individuals have the expectation of eating and to be served when dining at the same time as others. The findings included: 1. Resident #74 was admitted to the facility on [DATE]. The electronic medical record (EMR) for Resident #74 recorded a family member as his responsible party (RP). A 5/24/24 quarterly Minimum Data Set assessment, indicated Resident #74 had adequate hearing, rarely/never understood others, rarely/never understood by others, no speech, impaired short-term/long-term memory, severely impaired cognitive skills for daily decision making, and required substantial/maximal staff assistance with eating. On 6/17/24 a continuous observation of the lunch meal dining occurred on the south unit when the meal cart arrived on the unit at 12:08 PM until 12:48 PM. On 6/17/24 at 12:16 PM Resident #74 and Resident #55 were both observed in the same room. Resident #74 was in bed with the head of his bed elevated. The privacy curtain was observed open between the two Residents. Resident #55 was observed seated in his wheelchair with his lunch meal on his overbed table, he fed himself and at the time of the observation, he had eaten approximately 50% of his lunch. Resident #55 continued to feed himself until 12:21 PM and ate a total of approximately 75% of his lunch meal, while Resident #74 waited for staff to bring him lunch and assist him with his meal. The privacy curtain remained open between the two Residents while Resident #55 fed himself. NA #5 brought Resident #74 his lunch tray into his room at 12:25 PM, set up his meal tray, and fed him. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NA #5 was interviewed on 6/17/24 at 1:18 PM, she stated that Resident #74 required staff assistance with his meals and when she brought him lunch, his roommate, Resident #55 had already eaten. NA #5 stated she was aware that residents should eat together, but further stated that the facility used to offer a feeding program in the dining room where six residents from the south unit who required staff assistance with meals ate together, but she had not seen this done for the last few weeks. NA #3 stated in an interview on 6/17/24 at 1:19 PM that Resident #74 was in the room in his bed when she took the lunch meal into the room for his roommate, Resident #55. She stated she set up the tray for Resident #55 and he fed himself. NA #3 stated that she did not take a lunch tray into the room for Resident #74, because he required staff assistance with eating, and NA #5 usually fed Resident #74 after all the trays were passed to residents who fed themselves. NA #5 stated Resident #74 only had to wait a few minutes to get his lunch until all the trays were passed. NA #3 further stated that the facility used to take residents to the dining room who required staff assistance with eating, but she had not seen that occur in the last week. She stated that she did not recall the exact time she took a lunch tray into the room for Resident #55, but that he was one of the first Residents on the unit to receive his tray. NA #3 stated that she did not consider it a dignity issue that Resident #74 waited in his room to receive his lunch and to be fed by NA #5. On 6/20/24 at 12:29 PM, a phone interview with the RP for Resident #74, she stated Resident #74 had to be fed in facility #1 where he lived before, he moved to the current facility. The RP stated that while Resident #74 lived at facility #1, he ate at the same time as all the other residents and that he was accustomed to eating with others. The RP stated that Resident #74 should not have to wait a long time to be fed and that she would not want him to wait too long to eat. The Director of Nursing (DON) was interviewed on 6/19/24 at 6:00 PM. The DON stated that the facility was currently in transition to new management and working through the logistics of the facility's Focused Feeding Program, which was not currently available, but that residents sitting together for meals should eat or receive staff assistance to allow them to eat together. The Administrator was interviewed on 6/20/24 at 2:46 PM and he stated that staff should all be available during meals and that nurses needed to know that meal trays are on the halls so that all hands are on deck to assist residents with their meals and allow residents to eat together. 2. Resident #88 was admitted to the facility on [DATE]. A 4/16/24 quarterly Minimum Data Set assessment indicated Resident #88 spoke clearly, was understood by others, able to understand others, her vision was severely impaired, her hearing was adequate, her cognition was intact, and she required substantial to maximal staff assistance with eating. A care plan revised 4/30/24 indicated Resident #88 had self-care deficits related to poor muscle control and muscle stiffness. Interventions included for staff to set up her meal tray and to assist her with the completion of her meals. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A continuous observation of dining on the South Unit for the lunch meal occurred on 6/17/24 from 12:08 PM until 12:48 PM. Seven residents, which included Resident #88, were observed seated in their wheelchairs in the commons area of the south unit. Five of the seven residents received their lunch meal from 12:08 PM until 12:15 PM and fed themselves while Resident #88 waited for staff to assist her with her lunch meal. While she waited, Resident #88 responded yes when asked by the Surveyor if she was hungry, ready to eat and preferred to eat with the other residents who were eating around her. NA #3 brought Resident #88 her lunch meal at 12:20 PM, set up her meal tray and fed Resident #88 lunch. NA #3 stated in an interview on 6/17/24 at 1:19 PM that Resident #88 required staff assistance with meals. NA #3 stated that all the meal trays were passed first to residents who fed themselves and then staff provided meal trays to the six residents on the south unit who required staff assistance with meals which caused the residents who required staff assistance with eating to wait about 15 minutes to be fed. NA #3 stated that she was trained to feed more than one resident at a time and that she typically did that for breakfast, but that she did not typically do that for the lunch meal. NA #3 further stated that the facility used to take residents to the dining room who required staff assistance with meals, but she had not seen that occur for about a week. The Director of Nursing (DON) was interviewed on 6/19/24 at 6:00 PM. The DON stated that the facility was currently in transition to new management and working through the logistics of the facility's Focused Feeding Program, which was not currently available, but that residents sitting together for meals should eat or receive staff assistance to allow them to eat together. The Administrator was interviewed on 6/20/24 at 2:46 PM and he stated that nursing staff were trained they could assist more than one resident at a time with meals. He stated that all nursing staff should be available to assist residents during meals. He stated that nurses needed to know that meal trays are on the halls so that all hands are on deck to assist residents with their meals and allow residents to eat together. 3. Resident #16 was admitted to the facility 9/16/18. The electronic medical record (EMR) for Resident #16 recorded a family member as her responsible party (RP). A care plan, revised May 2024, indicated Resident #16 had self-care deficits related to severe cognitive impairment with interventions that included staff to set up her meal tray and to assist her with the completion of her meals. A 5/27/24 quarterly Minimum Data Set assessment indicated Resident #16 spoke clearly, usually understood by others, sometimes able to understand others, vision was impaired, had moderate difficulty hearing, her cognition was severely impaired, and she was dependent on staff for assistance with eating. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A continuous observation of dining on the south unit for the lunch meal occurred on 6/17/24 from 12:08 PM until 12:48 PM, seven residents, which included Resident #16, were observed seated in their wheelchairs in the commons area of the south unit. Six of the seven residents received their lunch meal from 12:08 PM until 12:20 PM while Resident #16 waited for staff to assist her with her lunch meal. While she waited, Nurse Aide (NA) #5 brought Resident #16 her lunch at 12:33 PM, placed it covered on the overbed table that was in front of the Resident, and left the Resident to answer another resident's call light. While Resident #16 waited for lunch, she repeated to herself, I am so sick. When asked by the Surveyor while she waited if she was hungry, Resident #16 replied, I am so sick and I am so hungry. NA #5 fed Resident #16 her lunch meal at 12:36 PM. NA #5 was interviewed on 6/17/24 at 1:18 PM, she stated that Resident #16 required staff assistance with her meals. NA #5 stated she was aware that residents should eat together, but further stated that the facility used to offer a focused feeding program in the dining room where residents who required staff assistance with meals ate together. NA #5 stated she did not see the focused feeding program offered for the last few weeks, and there were six residents on the south unit who required staff assistance with eating. NA #5 stated she thought it was against state rules to feed more than one resident at time and so she only fed one resident at a time so that she could give her attention to the resident she was assisting. On 6/20/24 at 11:47 PM, a phone interview with the RP for Resident #16, she stated Resident #16 had dementia now and would not know about her surroundings but when she was aware of her surroundings, she would not like to wait to be fed while others around her ate. The RP stated that at times when she visited Resident #16 between 1:00 PM to 2:00 PM at the facility, Resident #16 had not yet received assistance with her lunch meal, but other residents were eating or had already eaten. The Director of Nursing (DON) was interviewed on 6/19/24 at 6:00 PM. The DON stated that the facility was currently in transition to new management and working through the logistics of the facility's Focused Feeding Program, which was not currently available, but that residents sitting together for meals should eat or receive staff assistance to allow them to eat together. The Administrator was interviewed on 6/20/24 at 2:46 PM and he stated that nursing staff were trained they could assist more than one resident at a time with meals. He stated that all nursing staff should be available to assist residents during meals. He stated that nurses needed to know that meal trays are on the halls so that all hands are on deck to assist residents with their meals and to allow residents to eat together.

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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** 49160 Based on record review, resident and staff interviews the facility failed to implement their abuse policy and procedure in the areas of reporting immediately to administration and investigating when Resident #21 reported that a Nurse Aide (NA) intentionally hit her on the hand with a bed remote. This deficient practice occurred for 1 of 5 residents reviewed for abuse. The findings included: A review of the facility's North Carolina Resident Abuse Policy revised 10/3/2022 defined physical abuse as hitting, slapping, pinching, and kicking. The policy stated all allegations of Abuse, Neglect, Involuntary Seclusion, Injuries of Unknown Source, and Misappropriation of resident property must be reported immediately to the Administrator, Director of Nursing (DON) and to the applicable State Agency. If the event that caused the allegation involves an allegation of Abuse or serious bodily injury, it should be reported to the Department of Health (DOH) immediately, but not later than 2 hours after the allegation is made. The policy further stated Once the Administrator and DOH are notified, an investigation of the allegation or suspicion will be conducted. The investigation must be conducted within five (5) working days from the alleged occurrence. Resident #21 was admitted to the facility on [DATE] with a diagnosis of cerebral infarction (stroke). A review of the quarterly Minimum Data Set (MDS) dated [DATE] indicated Resident #21's cognition was intact, and she exhibited verbal and physical behaviors and rejections of care. A review of the care plan dated 5/6/24 revealed Resident #21 had a history of making false accusations against other residents and staff. The interventions included encouraging Resident #21 to vent and express her feelings and explaining the seriousness involved of making false accusations. An interview with NA #4 on 6/19/24 at 10:50 AM revealed she was unsure of the date, but Resident #21 had reported to her a 3rd shift NA was rough with her during care and had intentionally hit her across the hand with the bed remote. She stated Resident #21 was unable to recall the name of the 3rd shift NA. NA #4 revealed Resident #21 was very upset about the incident and would not allow her to provide morning care. NA #4 indicated she informed Medication Aide #1 and then found the Social Work Assistant and requested she meet with Resident #21 as soon as possible. An interview was conducted with Medication Aide (MA) #1 on 6/19/24 at 11:03 AM. MA #1 stated she was unable to recall the date, but during her morning medication pass she observed the Social Work Assistant interviewing Resident #21 in her room and overheard Resident #21 tell the Social Work Assistant that a Nurse Aide hit her with the bed remote. MA #1 had no other details regarding the incident. A review of the facility reported incidents revealed the facility had not reported or investigated the allegation by Resident #21 that a 3rd shift Nurse Aide intentionally hit her across the hand with a bed remote (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Initial Allegation Report submitted by the facility on 6/20/24 at 12:46 PM revealed Resident #21 reported a Nurse Aide had roughly taken a remote out of her hand hitting her hand with the remote. The report further revealed the facility became aware of the incident on 5/28/24 and no employee was named or accused. An interview was conducted with the Administrator on 6/20/24 at 2:18 PM. The Administrator stated he was not employed at the facility on 5/28/24. He stated Resident #21 reporting that a Nurse Aide hit her with a bed remote was an allegation of abuse and the facility's Resident Abuse policy and procedure should have been implemented.

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45380 Based on record review, Hospital Case Manager, and staff interviews, the facility failed to allow a resident to return to the facility after being sent to the hospital for a medical evaluation using the residents' behaviors prior to discharge as a basis for their decision for 1 of 3 residents reviewed for transfer and discharge (Resident #303). The findings included: Resident #303 was admitted to the facility on [DATE] with multiple readmissions and was last discharged on [DATE]. Diagnosis included dementia with severity and agitation, metabolic and hepatic encephalopathy, and acute metabolic acidosis. Review of nursing progress note dated 6/07/24 written by Unit Manager #1 revealed she went to check on Resident #303 to see if he would take his medications. Resident #303 stated I just want to die and disappear. Unit Manager #1 notified social worker of Resident #303 statement and his family would be notified. Review of facility Social Work progress note dated 6/07/24 revealed the social worker went to the magistrate to request IVC (involuntary commitment) for Resident #303 due to his verbalization of self-harm and refusal of taking medications. Social worker reported the magistrate approved for Resident #303 to be picked up from the facility to be transported to hospital by law enforcement. Resident #303 nursing staff and receptionist were notified. An interview with the Admission Director on 6/18/24 at 2:15 PM revealed she had been employed at the facility for 3 years and was familiar with Resident #303. She stated Resident #303 was sent out to the hospital on 6/07/24 as an involuntarily commitment due to behaviors and refusal of medications. She revealed last week on 6/11/24 she received a telephone call from the hospital case manager to discuss Resident #303 discharge back to the facility. She stated after the telephone call with the hospital case manager, she had emailed the facility clinical team about Resident #303 discharge back to the facility, when the Director of Nursing (DON) informed her Resident #303 would not be returning to facility. The Admission Director revealed she then went and spoke with the interim Administrator who stated the facility would not be allowing Resident #303 to transfer back due to the new company admission guidelines, refusing care and medications, on-going behaviors such as being verbally aggressive towards staff, and in his opinion clinically not being appropriate for skilled care. She stated on 6/11/24 she and the interim Administrator contacted the hospital case manager and informed why the facility would not be allowing Resident #303 to return and would need to locate alternative placement. (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Administrator on 6/18/24 at 2:40 PM revealed he had only been employed at the facility since June 1, 2024. He stated he was aware of Resident #303 being sent out to the hospital for an IVC on 6/07/24 and after reviewing his medical chart did not feel he was appropriate to return to the facility. He also stated that in his opinion, Resident #303 level of care should be revised, and he was not appropriate for skilled level of care, the facility had no safe way to provide care, due to him being verbally aggressive towards staff, refusing care and medications. The interim Administrator revealed he along with the Admission Director had spoken with the hospital case manager on a few different occasions and informed them why Resident #303 would not be allowed to return to the facility and an alternative placement would need to be located. A telephone interview with the hospital case manager on 6/20/24 at 11:43 AM revealed she was familiar with Resident #303 who had been admitted to the hospital by the facility under an IVC. She stated she had spoken with the Admission Director and the interim Administrator on few different occasions about Resident #303 being ready for discharge back to the facility and was told the facility would not be allowing him back and an alternative placement would need to be located. She revealed when asked why Resident #303 was not allowed to return, she was told that he was verbally aggressive towards staff, and they were not able to provide for his care. The hospital case manager stated Resident #303 was currently still at the hospital and they were continuing to look for placement. An interview with the Director of Nursing (DON) on 6/20/24 at 11:55 AM revealed she had been employed at the facility since April 2023 and was familiar with Resident #303 and his family. She stated Resident #303 had made statements regularly that he did not want to be at facility and would then refuse his medications or make statements of harm to get himself to the hospital and his family always wanted him to return. The DON revealed that during Resident #303 last care meeting on 6/06/24 they discussed with Resident #303 and his family about his behaviors, statements towards staff and refusal of medications and that if those things continued the facility would involuntarily commit him and not allow him to return to the facility. She stated a few days after the care plan meeting was when Resident #303 made a statement of harm to himself and refusing medications which led to him being involuntarily committed and sent to the hospital. She revealed that according to the new facility admission guidelines, Resident #303 would not meet criteria for admission, the facility would not be able to continue to provide for his care and felt was best that he did not return. When asked about why Resident #303 had never previously been issued a 30-day discharge notice while having these same behaviors, the DON stated she was not sure why that had not been done previously other than the facility would have still been responsible for finding Resident #303 placement and having him go to the hospital was easier.

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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** 45358 Based on record review and staff interviews, the facility failed to update the care plan to reflect self-administration of all medications and pick up medications from an outside pharmacy for 1 of 3 (Resident #353) sampled residents reviewed for care plans. The findings included: Resident #353 was readmitted to the facility on [DATE] with diagnoses that included bipolar disorder, blindness, and conduct disorder. A physician's order dated 5/3/23 indicated Resident #353 could self- administer all medications by mouth, topical and ophthalmic (eye drops) and pick up his own medications from an identified pharmacy. A physician's order dated 7/11/23 indicated all medications by mouth, topical and opthalmic (Tylenol, cetirizine, eye drops, protopic ointment, and topical eyebrow cream) were discontinued. A revised care plan dated 8/24/23 indicated Resident #353 was not care planned for no longer receiving medications from the facility due to refusals and the care plan was not updated to reflect the resident could self-administer all medications and pick up his medications from an outside pharmacy provider per physician's order 5/3/24. A quarterly Minimum Data Set assessment dated [DATE] indicated Resident #353 was cognitively intact and had not rejected care. A discharge Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #353 was cognitively intact and had not rejected care. During an interview on 6/20/24 at 10:00 am the Director of Nursing (DON) indicated Resident #353 would not talk to and refused care from the facility physician or nurse practitioner due to his paranoia. The DON further indicated the resident would schedule his own doctor appointments with outside providers the facility was not aware of, schedule his own transportation, pick up his own medications from a local pharmacy and did not want any care from the facility. The DON stated she was made aware in August or September 2023 who the resident's outside primary care physician was and what pharmacy he was using. The information was not added to the resident's face sheet until 10/2/24. The DON then stated the care plan should have been revised to reflect Resident #353's refusal to utilize the facility physician, nurse practitioner and in-house pharmacy. The care plan should have also been revised regarding the use of an outside pharmacy for which he was responsible for picking up and self-administering his medications. The DON also stated the care plan should have been updated to reflect when the self-administered medications were discontinued 7/11/23 during the resident's leave of absence. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 6/20/24 at 10:42 am with the MDS Coordinator revealed she took over as coordinator in April 2023, was still learning, and was responsible for updating/ revising care plans and that Resident # 353's care plan should have been revised to reflect changes and challenges related to self- administration and picking up his own medications from an outside pharmacy. The MDS Coordinator further revealed changes would have been discussed during morning meetings or identified through nurse notes, physician orders or nurse practitioner notes. During an interview on 6/20/24 at 2:50 pm the interim Administrator revealed the care plan should have been updated / revised accordingly for Resident #353 and was not. The interim Administrator further revealed education on updating the care plan accurately was necessary.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37019 Based on observations, record review, resident and staff interviews, the facility failed to provide Thrombo-Embolic Deterrent (TED) stockings as ordered by the physician on 11/07/23 and 01/09/24 for a resident with bilateral lower extremity edema (swelling and puffiness of bilateral lower legs, ankles, and feet) (Resident #65) for one of one resident reviewed for quality of care. The findings included: Resident #65 was admitted to the facility on [DATE] with diagnoses which included hypertension, lower extremity edema, and paraplegia (the inability to voluntarily move the lower parts of the body). Review of a physician's progress note written on 11/07/23 revealed Resident #65 was being seen for a regulatory visit with three or more chronic health problems and interval concerns were being addressed as in the assessment below. Under assessment and plan the note read in part: 9. Lower extremity edema: Chronic and ongoing. Patient appears to have some baseline lymphedema with no previous diagnosis. Mild 1-2 pitting edema noted. Patient sits in chair majority of the day. Patient states swelling does improve slightly overnight when legs are elevated in bed. Continue to monitor. We are going to place order for TED hose - to place in AM and take off at night and elevated as much as possible since this provides improvement. Review of Resident #65's physician orders revealed an order written on 11/07/23 for TED stockings to bilateral lower legs - apply stockings in the morning when resident gets up and take them off the resident at bedtime before going to bed. Review of Resident #65's physician orders revealed an order written on 01/09/24 for TED stockings to bilateral lower legs - apply stockings in AM and take them off at night prior to going to bed. Review of Resident #65's Medication Administration Record (MAR) for 01/09/24 through 06/19/24 revealed the TED stockings on almost all days and evenings were checked off by the nurses as being applied in the morning and being taken off at bedtime. Review of Resident #65's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed he was cognitively intact and required substantial to maximal assistance with upper body dressing, personal hygiene, and bed mobility. The assessment also revealed Resident #65 was dependent on staff for toileting hygiene, showers/bed baths, lower body dressing, putting on and taking off footwear and transfers. According to the assessment the resident had no behaviors including no rejection of care. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 06/19/24 at 10:11 AM revealed Resident #65 up in his wheelchair in his room dressed for the day. The resident stated he was supposed to get TED stockings months ago for his bilateral legs due to edema in his lower extremities. He said the edema was from his high blood pressure and sitting up in his chair for several hours a day. Resident #65 further stated he could not recall if they had ever been in to measure him for TED stockings and said he had not received his stockings. His lower legs, ankles and feet were observed to be swollen as he was sitting up in his wheelchair and there were no stockings on his legs just black non-skid socks. An interview on 06/20/24 at 11:10 AM with the Director of Nursing and the Central Supply (CS) clerk revealed they were aware Resident #65 had TED stockings ordered for bilateral lower extremity edema. The CS clerk stated she had ordered the stockings in November of 2023 and February of 2024 but had not received them. She stated she had not followed up with the company to inquire about the stockings. The DON stated their previous owners would not allow them to use other sources for getting supplies and told them they would have to wait for the contracted company to send them the stockings. An interview on 06/19/24 at 3:20 PM with Nurse #1 who was frequently assigned to care for Resident #65 during the 7:00 AM to 7:00 PM shift revealed she had documented his TED stockings as being put on him the morning of 06/19/24 and other dates that she had worked. Nurse #1 was asked to show the resident's TED stockings on him and when she pulled his blanket back to expose his legs, she stated they were not on him. She stated she depended on the NAs to put his stockings on him in the morning and had just assumed his NA had put them on, so she had checked it off on the MAR. A telephone interview on 06/19/24 at 5:11 PM with Nurse #5 who was frequently assigned to care for Resident #65 during the 7:00 PM to 3:00 PM shift revealed she had documented the TED stockings as being put on during the morning on dates she was assigned to Resident #65. Nurse #5 stated the NAs that work with him usually put his TED stockings on him and the nurses document it on the MAR. She said she just assumed it had been done so she signed off on it. Nurse #5 further stated she had never gone into his room and checked to see if he had the stockings on and said she was not aware the resident did not have TED stockings. A telephone interview on 06/19/24 at 5:17 PM with Nurse #6 who was frequently assigned to care for Resident #65 during the 7:00 PM to 7:00 AM shift revealed she had documented on the MAR his TED stockings had been removed prior to him going to bed at night. She stated she depended on the NAs working with the resident to take them off before he goes to bed. Nurse #6 further stated she marked it off on the MAR and the NA took care of taking them off. Nurse #6 indicated no one had told her he didn't have TED stockings and she said she had never gone into the room and checked to see if they were on or off Resident #65 because she assumed the NAs took care of it. An interview on 06/19/24 at 5:27 PM with Nurse Aide (NA) #2 revealed she was frequently assigned to care for Resident #65 during the 3:00 PM to 11:00 PM shift. She stated she had never seen Resident #65 with TED stockings on and said she had never taken them off him prior to putting him to bed at night. NA #2 further stated she had never seen TED stockings in Resident #65's room. An interview on 06/20/24 with Nurse Aide (NA) #1 revealed she was frequently assigned to care for Resident #65 during the 7:00 AM to 3:00 PM shift. She stated she had never put TED stockings on Resident #65 and said she had never seen TED stockings in his room. NA #1 further stated she had only placed non-skid socks on the resident after washing him up and getting him dressed for the day.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 20934 Based on observations, record review, and interviews with the wound physician and staff, the facility failed to maintain a dressing intact to a stage 3 sacral pressure ulcer for 1 of 2 sampled residents reviewed for pressure ulcers (Resident #35). The findings included: Resident #35 was admitted to the facility 2/13/17. Some of Resident #35's diagnoses included vascular dementia, Alzheimer's disease, mild protein calorie malnutrition (PCM), failure to thrive and stage 3 sacral pressure ulcer. A care plan revised 3/11/24 recorded Resident #35 had self-care deficits, required staff assistance with activities of daily living (ADL) and at increased risk for developing pressure ulcers due to a history of pressure ulcers, a current pressure ulcer, incontinence, and PCM. Interventions included staff assist Resident #35 with turning and positioning, provide incontinence care and wound care per physician (MD) order. Review of Resident #35's MD orders in the electronic medical record (EMR) recorded a 3/11/24 MD order to cleanse sacral pressure ulcer with wound cleanser, pat dry, apply silver calcium alginate (a debridement), cover with a dry dressing daily and as needed (PRN) until healed. A 5/6/24 MD progress note recorded Resident #35 was evaluated for chronic disease management, received hospice services, required total staff assistance with ADL, received treatment for a stage 3 pressure ulcer of the sacrum, and followed by wound care MD. The plan was to continue with current wound treatments. A 6/10/24 quarterly Minimum Data Set (MDS) assessment recorded Resident #5 had adequate hearing, impaired vision, clear speech, usually understood by others, sometimes understood others, always incontinent of bowel and bladder function and rejected care one to three days of the assessment period. The MDS assessment indicated Resident #35 was at risk for developing pressure ulcers and had an unhealed stage 3 pressure ulcer. The June 2024 Treatment Administration Record documented Resident #35 received wound care per MD order on Sunday, 6/16/24 at 2:30 PM. A 6/17/24 MD Wound Evaluation and Management Summary recorded Resident #35 had a current stage 3 sacral pressure ulcer, that measured 2 centimeters (CM) by, 1 cm, by 0.1 cm with moderate serous exudate (bloody discharge). The wound progress was described as not on goal with her behavior as a possible factor. The treatment plan recorded alginate calcium with sliver, apply once daily for 30 days, apply a gauze island border dressing once daily for 30 days. A 6/17/24 Wound Assessment Note, recorded by Unit Manager (UM) #4 recorded Resident #35 had a stage 3 pressure ulcer to the sacrum with full thickness that measured 2 cm by 1 cm by 0.1 cm, and moderate serous exudate noted as assessed by the wound MD during wound rounds on 6/17/2024. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/17/24 at 10:39 AM, Resident #35 was observed in her room in bed without a brief on or a dressing in place to her stage 3 sacral pressure ulcer. Nurse Aide (NA) #8 provided peri-care and applied a brief. On 6/17/24 at 11:00 AM a wound care observation for Resident #35 with the wound MD and UM #4 revealed the stage 3 sacral pressure ulcer was not covered with a dressing prior to the wound care provided by the wound MD. NA #8 was interviewed on 6/17/24 at 10:39 AM and stated that she had just completed peri care for Resident #35 for bladder incontinence. NA #8 described that she rounded when she came on shift around 7:00 AM on 6/17/24 and checked Resident #35's brief for incontinence, but her brief was dry. She stated that the previous NA did not report to NA #8 that Resident #35 did not have a dressing in place to her sacral pressure ulcer during rounds. NA #8 stated that she did not remove Resident #35's dry brief during rounds and that she could not say if a dressing was in place to the sacral pressure ulcer at the time (7:00 AM) but stated there was no dressing in place or in the brief at 10:30 AM that morning on 6/17/24 when she provided peri care to Resident #35 for the first time that shift. NA #8 described Resident #35 was always incontinent of bowel/bladder and that she provided peri care to Resident #35 before and found her a few times without a dressing in place to her wound; when that occurred, she told the nurse. The brief was observed wet without a dressing in the brief. Multiple attempts to interview the NA assigned to care for Resident #35 on the 11:00 PM to 7:00 AM shift were unsuccessful. On 6/17/24 at 10:41 AM, Nurse #8, the assigned nurse for Resident #35 on the 7:00 AM to 3:00 PM shift stated in interview that this was her first time as the assigned nurse for Resident #35, she was not aware that a dressing was not in place for Resident #35's sacral pressure ulcer and she had not provided wound care to this Resident before. During a phone interview on 6/19/24 at 5:01 PM with Nurse #10, she confirmed she was the 7:00 AM to 3:00 PM Nurse on the south unit where Resident #35 resided on Sunday 6/16/24 but stated that she could not continue the interview due to a family emergency. Nurse #10 ended the call. A follow up attempt to interview Nurse #10 was unsuccessful. A phone interview on 4/21/24 at 4:29 PM, Nurse #11 stated she worked Sunday, 6/16/24 on the 3:00 PM to 11:00 PM and 11:00 PM to 7:00 AM shifts through an agency. Nurse #11 stated she was the assigned nurse for Resident #35 on 6/16/24 but did not recall providing wound care to this Resident on her shift. Nurse #11 stated that when she worked, she provided wound care per MD order for residents assigned but that she did not recall being notified that Resident #35's dressing was not in place or asked to reapply a dressing to Resident #35's sacral pressure ulcer. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 6/21/24 phone interview at 8:40 AM with Nurse #9 revealed she worked at the facility and she was the assigned nurse for Resident #35 two days per week on the 7:00 AM to 3:00 PM and every other weekend. Nurse #9 described Resident #35 as declining due to poor nutritional status, received hospice services, incontinence care and wound care for a stage 3 sacral pressure ulcer. Nurse #9 stated that at times during incontinence care, the dressing to Resident #35's sacral pressure ulcer came off and sometimes the NA did not tell the nurse which meant Resident #35 was without a dressing to her pressure ulcer for a while. Nurse #9 stated that if she went to provide Resident #35 with treatment for her sacral pressure ulcer and a dressing was not in place, she asked the NA what happened, and often the response was that the dressing came off during incontinence care. Nurse #9 stated that when this occurred, she reminded the NA to tell the nurse so that the dressing could be reapplied. Nurse #9 stated that if a dressing came off during incontinence care, the NA was supposed to tell the nurse so that the nurse could put another dressing on, but that all the NA did not notify the nurse. UM #4 was interviewed on 6/18/24 at 4:44 PM and stated that Resident #35 received treatment for a stage 3 sacral pressure ulcer. UM #4 described that the pressure ulcer was taking a while to heal which could be contributed to Resident #35's poor nutritional status. UM #4 stated that she rounded with the wound MD on 6/17/24 and when wound care was provided to Resident #35, there was no dressing in place to the pressure ulcer, but a dressing should have been in place. UM #4 stated The MD order was for daily wound treatments changes and PRN, so that in the event the dressing came off the nurse should be notified so that a new dressing could be applied. UM #4 stated that due to the location of Resident #35's pressure ulcer, it was at risk for infection and for getting urine/feces in the pressure ulcer which along with her poor nutritional status, could also inhibit the healing of the pressure ulcer. A phone interview on 6/18/24 at 3:35 PM with Hospice Nurse revealed Resident #35 admitted to hospice services with a stage 3 pressure ulcer. The Hospice Nurse stated that it would be of concern if Resident #35's stage 3 pressure ulcer was not covered for an extended period which she described as not changed on the same shift of care. The Hospice Nurse described that the concern would be due to the location of the pressure ulcer, the high risk, if left uncovered, of the pressure ulcer encountering fecal/urine material that could inhibit the healing progress and increase the risk of infection. The Wound Physician (MD) was interviewed on 6/17/24 at 11:00 AM during his evaluation of Resident #35's pressure ulcer. He stated that there was no dressing in place for Resident #35's stage 3 sacral pressure ulcer prior to his evaluation on 6/17/24 during his wound rounds. The Wound MD stated that he would expect Resident #35's stage 3 sacral pressure ulcer to be covered and receive treatment per MD order, which included a MD order for treatment PRN. He further stated that if the dressing came off for any reason, he expected staff to reapply a dressing, per the MD order for PRN treatment and that the pressure ulcer should not be left open like this. A follow up phone interview on 6/19/24 at 4:32 PM, the Wound MD described that Resident #35's stage 3 pressure ulcer had been stagnant for a while which he attributed to her end-of-life status. He stated that Resident #35's behaviors of fighting, punching and scratching staff when staff tried to reposition the Resident used to contribute to the slow healing progress, but stated that since her decline she no longer displayed this behavior, and the current concern was her poor nutritional status. The Wound MD stated that when he assessed the pressure ulcer for Resident #35 on 6/17/24 during wound rounds, she did not have a dressing in place to the pressure ulcer. He further stated that he would be concerned if the pressure ulcer was left uncovered for more than an hour or two as stool/urine could get in the pressure ulcer which increased the risk for contamination and could also be a factor to slow down the healing process along with her nutritional status. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Director of Nursing stated in an interview on 6/18/24 at 4:59 PM that residents with treatment orders for wound care should have a dressing in place per MD order to prevent infection or the wound being contaminated with urine/feces.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38515 Based on record review and staff, physician, and resident responsible party (RP) interviews, the facility failed to discontinue a benzodiazepine medication (Ativan) used for anxiety as ordered by the physician for 1 of 5 residents reviewed for unnecessary medications (Resident #5). The findings included: Resident #5 was admitted on [DATE] to the facility with diagnoses that included anxiety, unspecified dementia with other behaviors. Review of Resident #5's physician orders from October 2023 revealed the following orders: - Ativan 0.5 milligram (mg) tablet - give 1/2 tablet by mouth twice a day for agitation/anxiety with a start date of 07/05/23 and an end date of 10/10/23. - Clonazepam (benzodiazepine medication) 0.25 mg tablet - give 1 tablet by mouth 3 times daily for anxiety with start date of 10/04/23 and an end date of 10/10/23. Additional review of Resident #5's physician orders revealed the following order written on 10/04/23: - discontinue Ativan and start clonazepam 0.25mg by mouth three times per day for anxiety with an effective date of 10/04/23. The order was received and transcribed by Former Unit Manager #1. Review of Resident #5's medication administration record revealed Resident #5 received both Ativan 0.5mg and clonazepam 0.25mg from 10/04/23 through 10/10/23. Review of Resident #5's most recent quarterly Minimum Data Set assessment dated [DATE] revealed he was severely impaired with no psychosis, behaviors, rejection of care, or instances of wandering. Resident #5 was coded as taking antianxiety and antidepressant medications. An interview with Resident #5's responsible party on 06/18/24 at 2:15 PM via telephone, revealed on 10/10/23, Resident #5 was sent to the hospital. The following day, she was contacted by a physician from the hospital who informed her that Resident #5 had been receiving Ativan and clonazepam. She continued, stating this was concerning since at a care plan meeting conducted on 10/04/23 it was discussed that the facility would discontinue the use of Ativan and start Resident #5 on clonazepam. She stated she contacted the Director of Nursing (DON) on 10/13/23 and discussed the situation with her and was informed that the continuation of Ativan with the dosing of clonazepam was a medication error and that the facility would investigate and re-educate the staff. Resident #5's responsible party reported he was able to return to the facility following a short hospitalization . (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was completed with Former Unit Manager #1 by telephone on 06/20/24 at 10:07 AM. She reported she remembered Resident #5 and verified she was the staff member that took the physician order to discontinue his Ativan and start clonazepam on 10/04/23. She stated at that the time, she was serving as the unit manager while also working as a hall nurse. Former Unit Manager #1 also verified that Resident #5 received both Ativan and clonazepam from 10/04/23 though 10/10/23 when the facility was contacted by his responsible party, alerting them to the error. She stated she did not know how or why she was able to add and start the clonazepam and did not enter in the discontinue Ativan order into the electronic health record. She reported with her serving as a hall nurse and the unit manager at the time the orders were written, she may have been overwhelmed or had become distracted while entering the orders and had forgotten to enter the discontinue Ativan physician order. She stated Resident #5 was sent out to the hospital on 10/10/23 for heart related issues and the hospital had identified that Resident #5 was prescribed the two medications and reached out to his responsible party who then, in turn, contacted the facility. Former Unit Manager #1 reported during the 7 days that Resident #5 received both the Ativan and clonazepam, she did not note any change in his behaviors or notice him being more lethargic or drowsy. During an interview with the Director of Nursing (DON) on 06/20/24 at 11:59 AM, she reported she remembered the incident and stated it was her understanding that Former Unit Manager #1 had received the telephone order and instead of writing two separate orders, one to discontinue Ativan and another to start clonazepam, she wrote both orders on one physician order form. She stated she could only assume that when Former Unit Manager #1 went to enter the order, she somehow overlooked the entry of discontinue Ativan which resulted in Resident #5 receiving both medications until Resident #5 discharged to the hospital on 06/10/23. The DON reported she completed an investigation into the error, re-educated Former Unit Manager #1 and other hall nurses and medication aides. The DON also stated she contacted the hospital and spoke to Resident #5's attending physician and spoke with him about possible side effects and was told there did not appear to be any adverse effects from Resident #5 receiving both medications. The DON reported during the days that Resident #5 received both Ativan and clonazepam, she did not receive one concern regarding excessive drowsiness, or other potential side effects from Resident #5 receiving both medications. The DON reported Resident #5 returned to the facility after a brief hospitalization . During an interview with the Medical Director on 06/20/24 at 11:14 AM, she reported the risks of taking both Ativan and clonazepam would be excessive drowsiness and respiratory depression. She reported she was not at the facility at the time of the investigation and stated it would be almost impossible for her to determine if Resident #5 had an adverse reaction due to receiving both Ativan and clonazepam. The Medical Director stated it was a medication error, but she was unable to state with certainty if it was a significant medication error.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20934 Based on a lunch meal test tray observation, record review and resident interviews (Resident #4, #70, #153 and #65), the facility failed to provide food per resident preference for taste and temperature for 4 of 4 sampled residents on the south unit reviewed for food palatability. This failure had the potential to affect a census of 93 residents who received food in the facility. The findings included: 1a. Resident #4's admitted to the facility was 10/31/20 and included diagnoses of type 2 diabetes mellitus, hypertension, and hyperlipidemia (high blood cholesterol). Resident #4's 5/17/24 annual Minimum Data Set (MDS) assessment recorded adequate hearing, adequate vision with corrective lenses, spoke clearly, understood, understands, severely impaired cognition, received a therapeutic diet and fed herself after staff assisted to set up her meal tray. Resident #4's care plan, revised May 2024 recorded she was at risk for altered nutrition due to her receipt of a regular therapeutic diet, with no added salt. Interventions included providing foods per her preferences. An observation of the lunch meal on 6/17/24 at 12:08 PM, revealed Resident #4's lunch meal tray card recorded a regular diet with no added salt. Resident #4 received ham and macaroni casserole, and spinach for lunch. Resident #4 fed herself lunch after staff assisted in setting up her tray. While eating her lunch, when asked if she liked her food, she stated, This macaroni is not good and it's not hot. Resident #4 did not eat the macaroni and ham casserole she received for lunch. 1b. Resident #70's re-admitted to the facility was 9/6/23 with diagnoses that included type 2 diabetes mellitus and hyperlipidemia. Resident #70's 4/26/24 quarterly MDS assessment recorded adequate hearing, impaired vision, spoke clearly, understood, understands, severely impaired cognition, received a mechanically altered, therapeutic diet and fed herself after staff assisted to set up her meal tray. Resident #70's care plan, revised 5/1/24 recorded she was at risk for inadequate nutritional intake due to her receipt of a mechanically altered, therapeutic diet. Interventions included providing foods per her preferences. An observation of the lunch meal on 6/17/24 at 12:19 PM, revealed Resident #70's lunch meal tray card recorded a mechanical soft textured no concentrated sweets diet. Resident #70 received ham and macaroni casserole, and spinach for lunch. Resident #70 fed herself lunch after staff assisted in setting up her tray. While eating her lunch, when asked if she liked her food, she stated, I don't like these greens, they are not hot. Resident #70 did not eat the spinach she received for lunch. 1c. Resident #153 was readmitted to the facility on [DATE] and included diagnoses of chronic renal failure and hypertension. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #153's 6/10/24 quarterly MDS assessment recorded adequate hearing, adequate vision, clear speech, understood, understands, intact cognition, received a therapeutic diet and fed herself after staff assisted to set up her meal tray. Resident #153's care plan, revised 6/14/24 recorded she was at risk for altered nutrition due to her receipt of a regular therapeutic diet, with no added salt. Interventions included providing foods per her preferences. An interview with Resident #153 and observation occurred on 6/19/24 at 12:43 PM. Resident #153's lunch meal remained covered and uneaten at the time of the observation. Resident #153 stated that she did not receive salt on her meal tray with her food, and she did not like the food. Resident #153 stated, They could do better with the food and add more seasonings, it's like they just open a can and pour it in the pot. 1d. The admitted for Resident #65 to the facility was 12/8/22 and included a diagnosis of hypertension. Resident #65's 5/13/24 quarterly MDS assessment recorded adequate hearing, adequate vision with corrective lenses, spoke clearly, understood, understands, intact cognition, received a therapeutic diet and fed himself after staff assisted to set up his meal tray. Resident #65's care plan, revised 5/24/24 recorded he was at risk for cardiac complications and altered nutrition regarding his diagnosis of hypertension and receipt of a therapeutic diet. Interventions included providing foods per diet order and preferences. Resident #65 stated in an interview on 6/17/24 at 4:49 PM that since the fall of 2023, he reported to dietary staff that he did not like the taste of the food and the facility served cold food. He stated that dietary staff advised that the facility served foods per the corporate menus/recipes which was out of the facility's control, so he asked his family to provide him food or he ordered out. Resident #65 provided pictures from his mobile phone for review of foods received at the facility dated October 2023 to May 2024. A follow up phone interview on 6/21/24 at 9:20 AM, Resident #65 stated he received fish cakes for dinner on Wednesday, 6/20/24, and described that the fish cakes were grey on the inside. He stated, When I bit into it, the fish should have been white, but it was grey, so I could not eat it. He further stated that the food at the facility was not the quality of food he should receive, and the food quality was just not good. 1e. A request for a lunch meal test tray from the tray line occurred on 6/17/24 at 11:58 AM. On 6/17/24 at 12:05 PM, 16 trays left the kitchen for delivery to the south unit and the cup of tea placed on the test tray in the kitchen contained ice cubes. The meal cart arrived on the south unit on 6/17/24 at 12:07 PM and two staff delivered meal trays to residents on the south unit until 12:48 PM. A sample of the lunch meal test tray occurred on 6/17/24 at 12:49 PM. The Certified Dietary Manager (CDM) removed the lid from the test tray and stated she did not see any steam coming from the food. The CDM added margarine to the food, which remained congealed and required continuous stirring to melt. The CDM tasted the food on the test tray and stated the macaroni and ham casserole would have been really good if it was hot, that it was slightly warm, but not hot. The CDM stated the spinach was not hot like it was when she tasted it in the past right off the line. An observation of the cup of tea on the test tray revealed the tea was without ice and had a watered appearance. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. Building B. Wing	06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saturn Nursing & Rehabilitation	1930 West Sugar Creek Road Charlotte, NC 28262

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the CDM on 6/18/24 at 12:25 PM for follow up she stated that she was aware of resident complaints of cold food on the weekends in September 2023 and since then she and the corporate dietary staff responded by completing test trays on the weekends. The CDM stated that when she conducted a test tray, she sampled food right from the tray line, monitored food temperatures in the kitchen and based on her weekend test tray audits of food right from the tray line, she had no current concerns with cold food. The CDM stated that if there were current concerns with cold food, nursing staff would need to increase the availability of staff to distribute meal trays to residents. She stated that there was one resident, she identified as Resident #65 who she stated complained for a while about the food, and that she told Resident #65 that dietary staff followed corporate menus/recipes, complaints were forwarded to the corporate office and that menu changes were out of her control. The CDM stated that the corporate office did not approve all the requested menu changes, but the dietary department changed what they could. The CDM stated she told residents about the alternate menu, but residents preferred to order food for delivery or have family provide them food. An interview on 6/20/24 at 1:40 PM with the District Training Dietary Manager revealed the facility was a new account for her, the facility was in transition to new management, she was unaware of resident complaints of food quality but that she would discuss that further with the CDM. The Director of Nursing (DON) interview on 6/19/24 at 6:00 PM revealed that the facility was currently in transition to new management and working through some of the logistics with dining services to provide residents with meals that were not cold, but palatable. The Administrator interview on 6/20/24 at 2:46 PM revealed that staff should all be available during meals, nurses needed to know that meal trays were on the halls so that all hands are on deck to assist residents with their meals and allow residents to receive hot food.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37019 Based on observations, record review, resident and staff interviews, the facility failed to ensure a resident's medical record accurately reflected that Thrombo-Embolic Deterrent (TED) stockings were not being applied in the morning and removed at night as ordered by the physician for a resident with bilateral lower extremity edema (swelling and puffiness of bilateral lower legs, ankles, and feet). This was for one of one resident (Resident #65) reviewed for accuracy of medical records. The findings included: Resident #65 was admitted to the facility on [DATE]. Review of Resident #65's physician orders revealed an order written on 01/09/24 for TED stockings to bilateral lower legs - apply stockings in AM and take them off at night prior to going to bed. Review of Resident #65's Medication Administration Record (MAR) for 01/09/24 through 06/19/24 revealed the TED stockings on almost all days and evenings were checked off by the nurses as being applied in the morning and being taken off at bedtime. Review of Resident #65's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed he was cognitively intact. Observation and interview on 06/19/24 at 10:11 AM revealed Resident #65 up in his wheelchair in his room dressed for the day. The resident stated he was supposed to get TED stockings months ago for his bilateral legs due to edema in his lower extremities. He said the edema was from his high blood pressure and sitting up in his chair for several hours a day. His lower legs, ankles and feet were observed to be swollen as he was sitting up in his wheelchair and there were no stockings on his legs just black non-skid socks. An interview on 06/20/24 at 11:10 AM with the Director of Nursing revealed she was aware Resident #65 had TED stockings ordered by the physician and said they had not received them from the durable medical equipment company they had ordered them from. She stated she was not aware the Nurses were documenting the TED hose as being put on in the morning and taken off at night. She further stated she would have expected them to have documented on the MAR that the stockings were not available and said the Nurses obviously needed education on accurately documenting in the resident's electronic medical record including the MAR. An interview on 06/19/24 at 3:20 PM with Nurse #1 who was frequently assigned to care for Resident #65 during the 7:00 AM to 7:00 PM shift revealed she had documented his TED stockings as being put on him the morning of 06/19/24 and other dates that she had worked. Nurse #1 was asked to show the resident's TED stockings on him and when she pulled his blanket back to expose his legs, she stated they were not on him. She stated she depended on the NAs to put his stockings on him in the morning and had just assumed his NA had put them on, so she had checked it off on the MAR. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A telephone interview on 06/19/24 at 5:11 PM with Nurse #5 who was frequently assigned to care for Resident #65 during the 7:00 PM to 3:00 PM shift revealed she had documented the TED stockings as being put on during the morning on dates she was assigned to Resident #65. Nurse #5 stated the NAs that work with him usually put his TED stockings on him and the nurses document it on the MAR. She said she just assumed it had been done so she signed off on it. Nurse #5 further stated she had never gone into his room and checked to see if he had the stockings on and said she was not aware the resident did not have TED stockings. A telephone interview on 06/19/24 at 5:17 PM with Nurse #6 who was frequently assigned to care for Resident #65 during the 7:00 PM to 7:00 AM shift revealed she had documented on the MAR his TED stockings had been removed prior to him going to bed at night. She stated she depended on the NAs working with the resident to take them off before he goes to bed. Nurse #6 further stated she marked it off on the MAR and the NA took care of taking them off. Nurse #6 indicated no one had told her he didn't have TED stockings and she said she had never gone into the room and checked to see if they were on or off Resident #65 because she assumed the NAs took care of it. An interview on 06/19/24 at 5:27 PM with Nurse Aide (NA) #2 revealed she was frequently assigned to care for Resident #65 during the 3:00 PM to 11:00 PM shift. She stated she had never seen Resident #65 with TED stockings on and said she had never taken them off him prior to putting him to bed at night. NA #2 further stated she had never seen TED stockings in Resident #65's room. An interview on 06/20/24 with Nurse Aide (NA) #1 revealed she was frequently assigned to care for Resident #65 during the 7:00 AM to 3:00 PM shift. She stated she had never put TED stockings on Resident #65 and said she had never seen TED stockings in his room.