STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345473	A. Building B. Wing	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wilora Lake Healthcare	6001 Wilora Lake Road Charlotte, NC 28212

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and resident and staff interview, the facility failed to provide personal privacy during incontinent care when the Nurse Aide exited the room during care and left the door to Resident #48's room open while the resident was unclothed and uncovered resulting in the resident being visible from the hallway while he was exposed. This deficient practice affected 1 of 1 resident reviewed for privacy (Resident 48). The findings included: Resident # 48 was admitted to the facility on [DATE]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #48 was cognitively intact, frequently incontinent, and dependent on assistance for activities of daily living (ADL). An observation of incontinent care provided by Nurse Aide (NA) #1 for Resident #48 was conducted on 2/12/25 at 6:22 AM. NA #1 placed gloves on her hands outside the room. She was observed to have washcloths and linen supplies in the room with running water in the bathroom sink. She wiped Resident #48 with the washcloth and placed a clean pad and draw sheet underneath Resident #48. NA #1 then placed Resident #48 on his back and gave him a urinal. Resident #48 was without clothing or covering when NA #1 opened the door to leave the room to get gloves. NA #1 did not cover Resident #48 or offer Resident #48 to be covered. NA #1 left the door open with Resident #48 exposed to the hallway. When NA #1 returned, she closed the door, then continued to assist Resident #48 in dressing for the day. An interview with Resident #48 was conducted on 2/12/25 at 6:40 AM. Resident #48 stated NA #1 would leave his room while his entire body was exposed. Resident #48 stated he was tired of NA #1 coming in his room like she was angry and leaving him exposed to the hallway for others to see him. Resident #48 verbalized he was unable to cover himself due to weakness after he had a stroke. An interview with NA #1 on 2/12/25 at 6:50 AM stated her normal process was to have all supplies in the room when providing incontinent care. If she needed to leave the room she would cover the resident, close the curtain and the door. NA #1 stated she had not realized she left the door open leaving Resident #48 exposed when she left the resident's room. The NA stated she should have shut the door since the resident was exposed. (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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/12/25 at 6:45 AM an interview with Nurse #4 stated the normal process when providing incontinent care was to take the linen bin and cart to the room to have all supplies and place dirty linen in bags. If staff needed to leave the room, privacy was provided with the curtain or covering the resident. The Director of Nursing (DON) interview was conducted on 02/13/25 at 1:16 PM. The DON stated that all supplies for incontinent care should be in all residents' rooms. The DON stated that when staff needed to leave the resident's room for any reason, staff should cover the resident for privacy and drop bed down in the lowest position for safety. The DON stated no staff member should leave a resident exposed. An Administrator interview was conducted on 02/14/25 at 11:02 AM. The Administrator stated staff should maintain privacy during incontinence care and keep doors closed and the curtain pulled to maintain privacy.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, resident, and staff interviews, the facility failed to protect a resident's right to be free from resident-to-resident abuse when Resident #20 hit Resident #7 on the back of his head and neck with a metal cane after Resident #7 entered back into their shared room to retrieve a personal item. Resident #7 had a raised red area on the back of his neck. This affected 1 of 3 residents reviewed for abuse (Resident #7). The findings included: Resident #7 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes and essential primary hypertension. A review of Resident #7's care plan updated on 12/23/24 read he had a psychosocial wellbeing problem potentially related to disease process. The goal read Resident #7 will demonstrate adjustment to nursing home placement through review date. The interventions included allowing time to answer questions and verbalize feelings perceptions, and fears and initiate referrals as needed. Review of the annual Minimum Data Set (MDS) dated [DATE] revealed that Resident #7 was cognitively intact and had no behaviors. Resident #20 was admitted to the facility on [DATE] with diagnosis that included end stage renal disease, essential primary hypertension, and unspecified intellectual disabilities. The quarterly MDS dated [DATE] indicated Resident #20 was moderately cognitively impaired, had no physical or verbal behavioral symptoms directed towards others, but did reject evaluation or care on a daily basis. A review of Resident #20's care plan last reviewed on 1/15/25 read he had potential to be physically aggressive when parting with possessions and trash, due to his belief he needed to save them. The goal read Resident #20 would not harm self or others, he would seek staff when agitation occurred and verbalize understanding of need to control physically aggressive behavior. Interventions included analyzing times of day, places, circumstances, triggers, and de-escalate behavior and document, assessing for contributing sensory deficits, and intervening before agitation escalated, guiding away from sources of distress, and engaging calmly in conversation. An initial allegation report dated 2/2/25 read Resident #7 was hit by Resident #20 with a cane. Residents were immediately separated, and Resident #7 had a bump on his head and a reddened area on his neck. Both residents remained separated. The report was signed by the Administrator on 2/2/25. A progress note for Resident #4 written by Nurse #5 dated 2/2/25 at 6:37 PM indicated Resident #7 was hit twice on the head with a cane by Resident #20 at 4:00 PM. Resident #7 was assisted to safety and assessed. The note further revealed a small red spot at the back of his head. The note read Resident #7 denied pain or discomfort and neurological checks were completed and Resident #7 was noted stable within his clinical baseline. He refused transport for evaluation at the emergency room. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse #5 was interviewed on 2/13/25 at 11:39 AM. She stated Resident #20 hit Resident #7 with his cane from behind when Resident #7 went back into his room to retrieve a personal item. She stated Resident #7 originally left the room because Resident #20 had been upset. Nursing Aide #8 separated them. She removed the cane and other metal objects from the room. Nurse #5 revealed Resident #7 had some redness on the back of his head but there was no swelling. She explained that she completed neurological checks as he refused transport to the hospital for evaluation, and he was fine. Nurse #5 stated Resident #7 wanted to be left alone and did not want to file charges with the police. A review of NA #5 witness statement was conducted. She heard Resident #7 crying out and saying he was being assaulted. She opened the door and found Resident #20 beating Resident #7 with his four-pronged cane while holding on to his chair. She stated Resident #20 was the only person fighting. She separated them. Multiple attempts were made to interview Nursing Aide (NA) #5 but were unsuccessful. An interview with Resident #7 on 2/13/25 at 12:34 PM revealed he was near the bathroom when he was hit on the head by Resident #20 with an object. He stated that he was moved to a different room after the incident. Resident #7 stated he couldn't recall exact details of the incident but stated he was not hurt, and he tried to get along with everyone in the building. The Social Worker (SW) was interviewed on 2/13/25 at 10:30 AM. She revealed Resident #20 did not like people near his belongings and it caused him to have aggressive behaviors. He had a roommate for a long time, and they were very compatible. When the roommate was discharged , she stated Resident #7 was a good match as Resident #7 had a lot of belongings. The SW explained staff was optimistic but after a couple of days together, Resident #20 became upset with Resident #7 in his space. The SW stated Resident #7 was moved to a private room for a day or two and wanted to move back. She stated when the incident occurred, Resident #7 removed himself from the room after Resident #20 became upset and he went back in to get his glasses. The SW explained Resident #7 took accountability for going back into the room when she discussed the incident with him the following day. She stated he was moved to the 400 hall and she set up counseling services for him. The DON was interviewed on 2/13/25 at 12:52 PM. She revealed Resident #7 went into the room to retrieve his glasses and then Resident #20 struck him with the cane. Resident #7 called out and staff separated them. The DON stated Resident #7 did not want to press charges and Resident #20 was sent to the hospital for evaluation. The Administrator was interviewed on 2/13/25 at 1:09 PM. He explained Resident #20 was aggressive when others were near his belongings, but he had not exhibited this level of aggressive behavior before this incident and wasn't generally a mean person. The Administrator stated Resident #20 was sent out for evaluation to the hospital after the incident.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff and physician interviews, the facility failed to maintain documented evidence of a thorough investigation of an allegation of misappropriation of medication for 2 of 4 residents (Residents #278 & #279) reviewed for misappropriation of property. Findings included: a. Resident #278 was admitted to the facility on [DATE] with diagnoses that included hypertension and non-Alzheimer's dementia. b. Resident #279 was admitted to the facility on [DATE] and discharged home on 7/31/24. Her diagnoses included Diabetes Mellitus. The Initial Allegation Report dated 2/20/24 revealed the facility became aware of an allegation of drug diversion of resident drugs on 2/20/24 at 8:30 AM. Resident #278 was noted to be the affected resident. The Facility Investigation Report dated 2/22/24 read in part on the summary of the investigation for alleged narcotics missing for Resident #278. The Director of Nursing (DON) was notified that the narcotic medication was unable to be located in the narcotic lock box for Resident #278. At approximately 8:05 AM on 2/20/24 Nurse #6 was interviewed, urine drug screen tested negative, and suspended until further investigation of the missing narcotic. The DON called Nurse #7 to request she come into the facility. Nurse #7 stated she was out of town and would report to the facility the next day when she was scheduled to work. Nurse #7 did not come or call out for work on her scheduled shift. She did not answer her phone when the DON called her. There was no documentation related to Resident #279. The Facility Investigation Report dated 2/22/24 continued to read the facility put the following interventions in place to ensure ongoing safety of residents. - Audit of Narcotics for residents from 2/17 through 2/22, no resident's affected. - Staff interviewed. - Review of Narcotic records of residents receiving narcotics, no resident's affected. - Quality Assurance monitoring was completed for staff, no staff witnessed any other staff member appropriating facility property. - Education for licensed nurses started on 2/22/24 provided for Misappropriation of Resident's Property. Education will be ongoing upon hire, annually, and as needed to ensure proper protocol for Narcotics. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 2/12/25 at 8:55 AM with Nurse #8 revealed that on 2/20/24 around 8:00 AM during morning shift narcotic medication count with Nurse #6, she had noted that Resident #278's discontinued narcotic medication had not been returned to the pharmacy. She also noted that Resident #279 had a new narcotic medication card and her previous card, which should have had pills on it, was missing. She stated she declined to take control of the narcotic keys from Nurse #6 and notified the DON of the medication abnormalities. An interview on 2/12/25 at 1:39 PM with the former Administrator revealed that the former DON completed the drug diversion investigation, and he had no direct knowledge of the investigation. An interview on 2/12/25 at 3:23 PM with the former DON revealed she was employed at the facility in February 2024 and completed this missing narcotic medication investigation. She stated she remembered the drug diversion and had left the completed investigation folder in the DON office. She stated the missing narcotics for Resident #278 and Resident #279 were not located. The former DON stated she did not know why only one resident, Resident #278, was identified on the facility reported investigation report faxed to the state agency or why Resident #279 was not listed on the report. An interview on 2/13/25 at 12:26 PM with the former Administrator and the [NAME] President of Clinical Operations revealed they had looked through the drug diversion investigation folder from the former DON's office and were unable to find the narcotic count sheets, substance inventory count sheets, staff interviews or audit sheets. An additional interview on 2/13/25 at 1:07 PM with the former DON revealed that all the investigation information was in the folder, and she had no further information. An additional interview on 2/13/25 at 1:37 PM with the former Administrator and the [NAME] President of Clinical Operations revealed they had been unable to locate any further documentation. Review of the facility investigation report documentation revealed that there were no documents for Resident #279 missing narcotics or that the BON was notified. The investigation folder revealed no shift control substance inventory count sheets for February 2024, no narcotic sign out sheets for Resident #278 or #279, no staff interviews, and no narcotic medication audit sheets. An interview on 2/13/25 at 1:40 PM with the Administrator revealed that he was not employed at the facility during this missing narcotic investigation and had no additional information.

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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** Based on record review, and staff and Regional Ombudsman interviews, the facility failed to provide a complete written notice of transfer/discharge that included the Nursing Home Hearing Request form to the Resident and Resident Representative for 1 of 3 residents (Resident #20) reviewed for facility-initiated discharge. The findings included: Resident #20 was admitted to the facility on [DATE]. The quarterly Minimum Data Set assessment dated [DATE] indicated Resident #20 was moderately cognitively impaired. A review of the record revealed Resident #20 had a Resident Representative (RR) listed as an emergency contact. A review of a nurse's progress note written by the Director of Nursing (DON) dated 2/2/25 revealed Resident #20 was sent to the emergency room for a psychological evaluation and treatment due to behaviors. The facility did not readmit Resident #20. An interview with the DON on 2/13/25 at 12:52 PM revealed she called Resident #20's RR on 2/3/25 and informed him that Resident #20 was admitted to the hospital and the facility would not accept him back due to his behaviors. She stated the Administrator consulted with the Regional Ombudsman and a discharge notice was issued to the hospital Social Worker for Resident #20. She stated she was unsure if Resident #20 or his RR received the notice sent to the hospital Social Worker. She stated she was not aware of any discussion related to issuing both pages of the transfer/discharge notice. A review of Resident #20's record revealed a notice of transfer/discharge form was completed by the Administrator on 2/3/25 but did not include the second page entitled Nursing Home Hearing Request form. A telephone interview was conducted with the Regional Ombudsman on 2/13/25 at 8:05 AM. She stated she had a telephone discussion with the Administrator and the DON regarding Resident #20's discharge from the facility. The facility emailed a copy of the transfer/discharge notice and upon receiving it, she informed the Administrator over email the form was not complete as it did not contain the second page of the notice for Resident #20 to appeal the discharge. An interview was conducted with the Administrator on 2/13/25 at 1:09 PM. The Administrator stated he did not attach the second page of the transfer/discharge notice on 2/3/25. He stated when he pulled up the form on his computer, it only included one page. He was not aware there was a second page for a Hearing Request until the Regional Ombudsman alerted him to it.

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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** Based on record review, and 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 #20). The findings included: Resident #20 was admitted to the facility on [DATE]. Diagnosis included end stage renal disease, essential primary hypertension, and unspecified intellectual disabilities. A review of a nurse's progress notes dated 2/2/25 revealed Resident #20 struck another resident with a cane, attempted to hit staff with objects and barricaded himself in his room. Resident #20 was sent to the emergency room for a psychological evaluation. A review of a second nurse's progress note dated 2/2/25 revealed Resident #20 was sent to the emergency room for a psychological evaluation and treatment due to behaviors. An interview with the Director of Nursing on 2/13/25 at 12:52 PM revealed she called Resident #20's Resident Representative (RR) on 2/3/25 and informed him that Resident #20 was admitted to the hospital and the facility would not accept him back due to his behaviors. She stated she called Resident #20's RR on 2/3/25 and explained that the facility was not an appropriate placement for him due to his aggressive behaviors. The DON stated a transfer/discharge notice was issued on 2/3/25 and a copy was given to the hospital social worker. She explained the hospital social worker initially pressured them to accept Resident #20 back to the facility. She stated Resident #20's family came and retrieved his belongings. Multiple attempts were made during the survey to interview the hospital social worker and were unsuccessful. An interview with the Administrator on 2/13/25 at 1:09 PM revealed he was aware Resident #20 was sent to the hospital after an incident where Resident #20 struck another resident with a metal cane. He stated Resident #20 would not return to the facility due to his behaviors and his diagnosis of an intellectual and developmental disability (IDD). The Administrator stated his other residents in the facility would not be safe if Resident #20 returned to the facility due to his aggressive behavior he exhibited when others were near his belongings. He stated the hospital social worker pushed to have Resident #20 return to the facility, but he stated she understood after a notice of transfer/discharge was issued. He stated the hospital would have to find placement for him. He indicated the hospital social worker would have a hard time placing Resident #20 in another facility. The Administrator was informed by the survey team on 2/14/25 at 11:08 AM that there was an expectation for the facility to allow Resident #20 to return. (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A telephone interview with the hospital case manager occurred on 2/19/25 at 9:31 AM. She stated she was familiar with Resident #20 as he was inpatient at the hospital as of 2/19/25. She explained the case management team was actively looking for placement in another facility for him. The Hospital Case Manager stated she had a discussion with the Administrator on the afternoon of 2/14/25. She indicated the facility would not accept Resident #20 back to the facility due to his ongoing verbal and physical aggression towards staff and other residents. She stated Resident #20 had been cleared for medical discharge for many days and was currently waiting on placement in a facility.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. Resident #73 was admitted to the facility on [DATE]. His diagnoses included muscle weaknessand adult failure to thrive. Resident #73 had a discharge home with spouse care plan in place initiated on 11/07/2024. Interventions included discuss with the resident/resident's representative/caregivers the prognosis for independent or assisted living and identify, discuss and address limitations, risks, benefits and needs for maximum independence. The discharge Minimum Data Set (MDS) dated [DATE] revealed Resident #73's discharge location was an acute hospital. Resident #73 was moderately cognitively impaired and had active discharge planning in process. Review of Resident #73's electronic medical record on 2/12/2025 revealed documentation that Resident #73 discharged home on [DATE] with family. An interview was completed with the Social Worker on 2/12/2025 at 9:47 AM who stated Resident #73 was admitted to the facility for short term rehabilitation with discharge plans to return home with family. The Social Worker explained she arranged home health services, and no durable medical equipment was indicated. The Social Worker was not aware of Resident #73 discharging to the hospital from the facility. The Social Worker expressed Resident #73 discharged from the facility on 11/27/2024 to home with family. An interview was completed on 2/12/2025 at 10:04 AM with the traveling MDS Nurse. The traveling MDS Nurse stated she would have reviewed the resident's progress notes and would have been involved with discharge planning- inclusive of discharge location. The traveling MDS Nurse was not certain why the discharge location was not coded accurately. The traveling MDS Nurse further stated the discharge location should be accurately reflected in the MDS for discharge location. An interview with the Administrator was completed on 2/12/2025 at 11:00 AM. The Administrator voiced the MDS should be coded accurately to reflect the actual discharge location of the resident. A telephone interview was completed on 2/13/2025 at 3:28 PM with the previous MDS Nurse. She explained she coded the discharge location in error for Resident #73. Based on record review and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of prognosis for a resident receiving Hospice services and discharge location for 2 of 27 reviewed for accuracy of assessment (Resident #9 and Resident #73). The findings included: 1. Resident #9 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD), chronic respiratory failure with hypoxia, and adult failure to thrive. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Hospice contract dated 01/14/2025 certified that Resident #9 was admitted under the care and services of Hospice for end of life. Further review of the Hospice admission documentation for Resident #9 indicated that a certification of Resident #9's prognosis of 6 months or less was received on 01/14/2025 at 9:24 AM. A significant change MDS assessment dated [DATE] had been completed. Resident #9 was cognitively intact and received Hospice services. Resident #9's prognosis of 6 months or less was coded no. A telephone interview on 02/13/2025 at 3:28 PM with the previous MDS Coordinator revealed that she coded no for the significant change MDS assessment dated [DATE] as she had no certification of the prognosis of 6 months or less. She explained she had coded yes to Section O-Special Treatments/ Services as she had been advised that Hospice services had been initiated for Resident #9. An interview on 02/14/25 at 11:27 AM with the Administrator indicated that the MDS assessment should be accurate.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations,and family, staff, and Nurse Practitioner interviews, the facility failed to implement fall prevention interventions consistent with resident's care plan (Resident #5 and Resident #6) and failed to provide a safe transfer using a mechanical lift for Resident #36. This deficient practice occurred for 3 of 6 residents (Resident #5, Resident #6 and Resident #36) reviewed for accidents. The findings included: Resident # 6 was admitted to the facility on [DATE]. Diagnosis included cerebral infarction with right side weakness, muscle weakness, unspecified dementia, and unsteady on feet. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #6 was severely cognitively impaired, required partial to moderate assistance for transfers, walking not attempted due to safety, no falls prior to admission and one fall since admission with no injury. The incident report dated 1/28/25 revealed that an aide and nurse observed resident sitting on buttocks on the floor in front of wheelchair at nurse's station. Resident #6's predisposing physiological factors were confused, gait imbalanced, and impaired memory. No injuries were observed, Resident #6 denied pain and was not sent to the hospital. Fall was reported to Physician and family member. The incident report dated 2/5/25 revealed the nurse was in the middle of her medication pass when an aide notified her Resident #6 was on the floor. Resident #6's was ambulating without assistance. Resident #6's predisposing physiological factors were confused, gait imbalanced, and impaired memory. No injuries were observed, Resident #6 denied pain and was not sent to the hospital. Fall was reported to Physician and family member. Resident #6's care plan updated 02/05/25 revealed a focus on resident was a fall risk related to weakness. Goal to minimize the risk of falls. Interventions included anticipating resident's needs (1/27/25), maintaining call bell in in resident's reach (1/27/25), Dycem (sticky nonslip material) to wheelchair cushion (1/28/25), fall mat x1 while resident was in bed (2/5/25), and low bed position (2/5/25). An observation completed on 2/10/ 25 at 1:07 PM revealed Resident #6 was asleep in the bed which was in the lowest position and a fall mat was not observed in the room. An observation completed on 2/11/25 at 2:00 PM revealed Resident #6 was sleeping in the bed which was in the lowest position and a fall mat was not observed in the room. An in person interview with Resident #6's family member on 2/10/25 at 12:13 PM revealed Resident #6 fell twice in her room while in the facility. The family member verbalized she was notified of both falls and that Resident #6 was not injured. The family member stated the facility informed her that a fall mat would be placed in Resident #6's room after Resident #6's first fall on 01/28/25 and she had never observed a fall mat in Resident #6's room. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse #4 stated during an interview on 2/12/25 at 6:20 AM, Resident #6 would try to get out of bed without assistance during the 11:00 PM to 7:00 AM shift; however, Resident #6 has not had a fall while she was assigned to Resident #6. Nurse #4 verbalized she would observe Resident #6 often for fall risk and if she observed Resident #6 getting out of bed without assistance, Nurse #4 would assist Resident #6 into a wheelchair and have Resident #6 sit by Nurse #4 at the nurse's station. Nurse #4 stated she had never seen a fall mat in Resident #6's room and did not recall if a fall mat was included in Resident #6's care plan. An interview with Nurse #3 on 2/13/25 at 10:20 AM stated she had been assigned to Resident #6 and was not aware Resident #6 did not have a fall mat in her room or required a fall mat. Nurse #3 verbalized that she did not know who would place the fall mat if ordered and did not know where fall mats were stored. Nurse Aide (NA) #4 was interviewed on 2/13/25 at 12:46 PM and stated that NA #4 had not worked with Resident #6 before being assigned to Resident #6 on 2/13/25 and had not observed a fall mat in the room. NA #4 also verbalized if she needed a fall mat she would ask the assigned nurse for assistance. An interview was conducted with the Director of Nursing (DON) on 02/13/25 at 1:02 PM. The DON stated when a resident had a fall it was discussed during the morning meeting with representatives from each facility discipline. The DON verbalized fall interventions were discussed and decided as a group, then the Minimum Data Set (MDS) Nurse would add the intervention to the resident's care plan. The representative from maintenance or housekeeping would retrieve the fall mat and place the fall mat in the resident's room. The DON stated that the nurse would assess if the fall mat was in place and the intervention was completed. DON verbalized the fall mat should have been in the room. An interview with the Administrator on 02/14/25 10:52 AM stated falls would be communicated in the facility team morning meeting to address prevention for future falls. The Administrator verbalized fall mats were placed by nursing, maintenance, or unit manager who all have access to storage. Fall mats were cleaned in a resident's room and removed once the resident was discharged from the facility. The Administrator stated that the method of fall prevention was communicated with family and then should be validated by nursing that fall mat was in place. 3. Resident #36 was admitted to the facility on [DATE] with diagnoses including a chronic neurologic disorder and hypertension. The care plan dated revised 04/13/22 and revealed Resident #36 had a problem area related to activities of daily living self-care performance deficit due to impaired mobility and one intervention was to use a mechanical lift and two-person assistance for transfers (added 08/09/21). The quarterly Minimum Data Set (MDS) dated [DATE] indicated Resident #43 was cognitively intact. An interview conducted with Resident #36 on 02/11/25 at 9:10 AM revealed that Resident #36 had no recollection of the fall that occurred on 02/08/24. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility incident report dated 2/8/24 at 7:02 PM written by the previous Director of Nursing (DON) revealed Resident #36 was being transferred with the mechanical lift when Nurse Aide (NA) #8 attempted to lift Resident #36 on mechanical lift and Resident #36's weight shifted causing the lift to tilt. The report indicated Resident #36 slid off the bed to the floor. Assessment was completed and no injuries were noted, and Resident #36 was able to move all extremities without difficulty and denied hitting her head. A review of a nursing progress note written by the former DON on 2/8/24 revealed she spoke to the Nurse Practitioner (NP) regarding Resident #36's fall as well as Resident #36's Resident Representative (RR). She noted no injuries were present. A telephone interview with Resident #36's RR on 2/12/25 at 10:39 AM revealed NA #8 was bringing Resident #36 back to her room from a shower. When she was transferring her into the bed, she proceeded to move Resident #36 to her bed and the lift tilted over and she fell on the other side of the bed. The RR stated she asked to have mobile x-rays completed and she stated the results were negative for any fractures. The RR indicated she was not present during the incident but was notified after it occurred. An interview with NA #8 on 2/12/25 at 5:13 PM revealed she worked with Resident #36 on 2/8/24 and was bringing her back to her room after a shower. When she transferred her using the mechanical lift, the lift tilted forward, and Resident #36 ended up on the other side of the bed, in between the wall and the bed. She stated Resident #36 remained in the lift pad which was near the floor. She called for help and NA #7 assisted her with the mechanical lift. NA #8 stated she believed the base of the lift was caught on a part of the bed and Resident #36's weight shifted causing the lift to lean forward. NA #8 did not indicate a reason why she transferred Resident #36 alone but acknowledged that she was aware all mechanical lifts required two-person assistance. An interview with NA #7 occurred on 2/12/25 at 5:25 PM. She stated she happened to be walking down the hallway on 02/08/24 when NA#8 called for help. She stated she went in to assist her and saw Resident #36 on the other side of the bed between the bed and the wall seated in the mechanical lift pad which was near the floor. She explained she helped lower Resident #36 to the floor with the mechanical lift for Unit Manager #1 to assess her. NA #7 stated that after Resident #36 was assessed by Unit Manger #1, she and NA #8 used the mechanical lift to put Resident #36 back into the bed. A telephone interview with the former DON on 2/12/25 at 3:39 PM revealed NA #8 was using the mechanical lift to place Resident #36 in bed. The bed was not against the wall and the lift leaned forward and the Resident #36 fell in the lift pad towards the floor. She stated NA #8 did not have an additional NA to assist her with the mechanical lift transfer as their staff has been instructed to do. The former DON stated Resident #36's skin assessment was clear upon assessment with no injuries noted and she was noted to have normal range of motion. The former DON confirmed that she responded to the room at the time of the incident and assisted Unit Manager #1 with assessing Resident #36, who was noted to have no injury. Multiple attempts were made to contact Unit Manager #1 during the survey and were unsuccessful. An interview with the NP on 2/14/25 at 9:08 AM revealed she was unsure if she took the call on 2/8/24 when the incident occurred, but stated their office was notified of the incident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Director of Maintenance on 2/12/26 at 3:20 PM revealed he inspected the mechanical lifts after the accident on 02/08/24 and took one lift out of circulation because the manual lever was not operating correctly to open the legs on the base of the lift. The Director of Maintenance could not confirm that the lift that did not work properly was the lift used on Resident #36 on 2/08/24 but he did take it out of service. An interview was conducted with the Former Administrator on 2/13/25 at 1:18 PM revealed he was made aware of the mechanical lift incident with Resident #36 when the lift titled forward and placed Resident #36 on the other side of the bed, between the wall and her bed. He noted the staff assisted her by lowering her down with the mechanical lift to the ground for assessment. He stated NA #8 should not have used the mechanical lift by herself and the accident was caused by operator error. 2. Resident #5 was admitted to the facility on [DATE] with diagnoses that included cerebrovascular accident and Diabetes Mellitus. Review of Physician's orders for Resident #5 revealed an order dated 4/23/24 for a fall mat to the left side of bed every shift. Review of Resident #5's care plan last revised 12/22/24 revealed a focus that read in part that the resident has potential for falls related to impaired mobility, incontinence, and unawareness of safety needs. An intervention read for a floor mat at bedside. Review of Resident #5's fall report dated 12/22/24 at 5:00 PM revealed the resident was found on the floor laying on the fall mat with no visible injuries noted. The quarterly Minimum Data Set, dated [DATE] revealed Resident #5 had moderately impaired cognition, was dependent on staff for most activities of daily living and had no refusals of care. She was coded for one fall with no injury during the 7 days look back period. An interview on 2/10/25 at 6:09 PM with Resident #5's responsible party revealed that the resident had a history of falls and used to have a fall mat, but it had not been in the resident's room lately. She was unable to say when she last saw the fall mat but thought it should be by her bed when she was in the bed. An observation on 2/11/25 at 12:45 PM revealed Resident #5 in bed with no fall mat by her bed. There was no fall mat observed in the room or adjoining bathroom. An observation on 2/11/25 at 3:20 PM revealed Resident #5 in bed with no fall mat by her bed. There was no fall mat observed in the room or adjoining bathroom. An observation on 2/12/25 at 8:10 AM revealed Resident #5 in bed with no fall mat by her bed. There was no fall mat observed in the room or adjoining bathroom. An observation and interview on 2/12/25 at 8:11 AM with the Director of Nursing (DON) in Resident #5's room revealed the resident was in the bed and no fall mat was by her bed. There was no fall mat observed in the room or adjoining bathroom. The DON stated the resident was supposed to have a fall mat and she did not know why there was no fall mat by Resident #5's bed or in the room. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 2/12/25 at 8:19 AM with Nursing Assistant (NA) #5 revealed she was assigned to provide care for Resident #5 that day and provided care for her regularly. She stated she was not aware Resident #5 was supposed to have a fall mat and had not seen one in her room. An interview on 2/12/25 at 11:24 AM with Nurse #5 revealed she was assigned to Resident #5 that day and had been assigned to her in the past. She stated she was not aware the resident was care planned for a fall mat. She stated she had observed a fall mat in the resident's room a week or so ago when she assisted housekeeping and doesn't know what happened to it. An interview on 2/12/25 at 1:49 PM with the Administrator revealed that Resident #5 should have a fall mat beside her bed. He stated he thought that when the room was deep cleaned by housekeeping, they removed the fall mat to clean it and had not returned it to the room. He stated this was an oversight on the facility's part. An interview on 2/12/25 at 1:58 PM with the Housekeeping District Manager revealed that fall mats or equipment were not removed from the room during deep cleaning. He stated they were wiped and left in the room.

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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. Based on observations, record reviews, and staff interviews, the facility failed to disinfect a resident's dedicated glucometer according to manufacturer's guidelines for cleaning and disinfecting glucometers for 1 of 2 residents observed for infection control practices (Resident #69). The findings included: Review of the glucometers manual revealed only wipes with environmental protection agency (EPA) registration number listed in the tables could be used to clean the glucometers. Resident glucometers should be cleaned with EPA regulatory wipe once for cleaning followed by one wipe for disinfecting. Then allow the glucometer to dry for 3 minutes. The facility's infection control policy on disinfecting glucometer (Not Dated) included: 1. Wear appropriate protective gear such as disposable gloves. 2. Open the cap of disinfectant container and pull out 1 towelette to clean the meter and close the cap. 3. Wipe the entire surface of the meter 3 times horizontally and 3 times vertically using 1 towelette. Carefully wipe around the test strip port. 4. Properly dispose of the used towelette. 5. Open the towelette container and pull out 1 towelette to disinfect the meter and close the lid. 6. Wipe the entire surface of the meter 3 times horizontally and 3 times vertically using 1 towelette. Carefully wipe around the test strip port. 7. Properly dispose of the used towelette. 8. Treated surface must remain wet for recommended contact time. Please refer to the Assure Prism Multi BGMS User Manual for hepatitis B contact times. For all other contact times, refer to the wipe manufacturers' instructions. DO NOT WRAP THE METER IN A WIPE. Once contact time is complete, wipe meter dry. 9. After disinfection, the user's gloves should be removed and thrown away. Wash hands before proceeding to the next patient. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a medication pass/continuous observation on 02/13/25 at 4:25 PM, Nurse #3 was observed taking Resident #69's glucometer out of medication cart and obtained a blood sample from Resident #69 to monitor blood sugar level with Resident #69's personal use glucometer. When Nurse #3 completed monitoring Resident #69's blood sugar, she placed the glucometer on the medication cart, removed gloves from her hand, retrieved an alcohol 4 x 4-inch pad, and began to clean the glucometer with the one alcohol pad. Nurse #3 placed the glucometer in Resident #69's storage case immediately after cleaning with alcohol pad and placed glucometer back in the medication cart. Nurse #3 stated she cleaned all the residents' individual glucometers with the white top wipes (EPA approved wipes) in the morning and used the alcohol pads for the rest of the day because it was just the way she cleaned glucometers. Nurse #3 verbalized she completed the facilities online computer-based glucometer training when she was hired two months ago. During the interview with the Director of Nursing (DON) on 02/13/25 at 04:35 PM, the DON stated staff should use white top wipes with bleach and wait for a wet (3-minute dry time) time after the use of the glucometer and should have gloves on when cleaning the glucometer. The DON verbalized that all nursing staff have a supply of white top wipes or could request more white top wipes if needed. DON stated there was never a reason to use any other form of disinfecting and cleaning of the glucometer other than using the white top wipes. In an interview with the Administrator on 2/14/25 at 10:42 AM, he stated that all staff received training on operating and cleaning glucometers based on the manufacturer's booklet. The Administrator verbalized glucometer training took place at the time of hire and then validated by return demonstration by the staff member. A copy of the skills validation was kept by the Director of Nursing per the Administrator. The Administrator stated the type of wipes needed to clean the glucometer was included in staff training.