STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345329	A. Building B. Wing	12/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gateway Rehabilitation and Healthcare	2030 Harper Avenue NW Lenoir, NC 28645

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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 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49160 Based on record review, and resident, staff, and detective interviews, the facility failed to protect the resident's (Resident #70) right to be free from misappropriation of property when Housekeeper #1 used Resident #70's debit card to set up a mobile payment application account on his [Housekeeper #1's] phone without Resident #70's permission or knowledge. Housekeeper #1 was alleged to have sent approximately $4,000.00 of unauthorized payments from Resident #70's bank account to his mobile payment application account from February 2024 to May 2024. Resident #70 stated, I am poor and he took everything I had. He indicated he was very upset that someone he trusted had taken advantage of him and he was worried to death over the loss of money and the potential for identity theft. This deficient practice occurred for 1 of 3 residents (Resident #70) reviewed for abuse, neglect, and misappropriation of resident property. The findings included: Resident #70 was admitted to the facility on [DATE]. A review of the quarterly Minimum Data Set (MDS) dated [DATE] indicated Resident #70 was cognitively intact. A review of the facility's reportable incidents revealed an initial allegation report dated 5/30/24 indicating the facility became aware on 5/29/24 that money was transferred from Resident #70's bank account to a former employee's (Housekeeper #1) mobile payment application account. The report indicated there was reasonable suspicion of a crime, and the alleged misappropriation of resident property was reported to law enforcement on 5/30/24. A review of Resident #70's bank account records from January 2024 to May 2024 revealed there were transactions of sending money from Resident #70's bank account to mobile payment application accounts starting on 2/05/24 along with overdraft fees charged by the bank. There were five transactions on 2/05/24, each sending $10.00 to Housekeeper #1's mobile payment application account. Transactions sending money from Resident #70's bank account to various mobile payment application accounts, including Housekeeper #1's, continued to recur several times a day from 2/5/24 through 5/6/24 in amounts ranging from $5.00 to $60.00. The transactions made to mobile payment application accounts and the bank overdraft charges totaled approximately $4,000.00. A review of the police department incident report indicated a report was filed on 5/10/24 at 11:11 AM concerning Resident #70 and stolen money from his bank account. (continued on next page)

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

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F 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview with Resident #70 was conducted on 12/20/24 at 11:27 AM. Resident #70 stated he was very sick and had not been able to use his debit card or monitor his bank account after his admission to the facility. Resident #70 revealed he did not recall the date, but a week or 2 after he was admitted to the facility, he asked Housekeeper #1 if he would purchase him a drink from the facility's vending machine. He indicated he gave Housekeeper #1 his debit card, he purchased the drink and then returned his debit card. Resident #70 revealed that was the only time he recalled Housekeeper #1 having possession of his debit card. He revealed a few months later the Business Office Manager (BOM) came to see him to discuss paying his bill. Resident #70 indicated he realized his debit card was missing and he asked the BOM to assist him with calling the bank to request a new card. He stated when they called the bank, he was informed that his account had been overdrawn for several months due to debit transactions that were made to a mobile payment application account. Resident #70 revealed he never had an account with a mobile payment application, and the only time his debit card was used after his admission to the facility was when Housekeeper #1 purchased him a drink from the vending machine. He further revealed he was not aware of any other staff members having possession of his debit card which indicated to him Housekeeper #1 was responsible for taking his money. Resident #70 stated, I am poor and he took everything I had. He indicated he was very upset that someone he trusted had taken advantage of him and he was worried to death over the loss of money and the potential for identity theft. Resident #70 indicated that he was interviewed by the police and wanted to press charges against Housekeeper #1, but there was not enough evidence to charge him, and the case was closed. An interview with the BOM on 12/11/24 at 11:37 AM indicated she did not recall the date but at the end of April she met with Resident #70 to discuss payment of his monthly bill, and he told her he lost his debit card and needed assistance contacting the bank. She revealed they called the bank a few days later and were informed that Resident #70's account had been overdrawn since January and there were several transactions of sending money to a mobile payment application account. She indicated that Resident #70 did not know what a mobile payment application was and had never set up an account. The BOM stated she obtained Resident #70's bank account records with is his permission from January 2024 to May 2024 and reviewed them on 5/10/24. She revealed there were several transactions sending money to various mobile payment application accounts, one of which was Housekeeper #1's. The BOM stated she contacted the mobile payment application company, and they informed her Housekeeper #1 had opened an account linked to Resident #70's debit card. She stated she immediately notified the Former Administrator of the concern, and he called the police. The BOM indicated the police assigned a detective to the case and an investigation was completed but no charges were filed. She revealed when the detective requested records from the mobile application company, he was told they had no record of Housekeeper #1's account. She stated she worked with the bank and tried to get them to credit the money Resident #70 lost but they would only go back 60 days from the date they became aware of the fraudulent activity. She indicated that Resident #70 agreed to set up a trust account managed by the facility and his social security check began to directly deposit into the account in June. The BOM revealed that Resident #70 had an outstanding bill with the facility that she planned to write off. An attempt was made to call Housekeeper #1 on 12/11/24 at 3:36 PM and the number was no longer in service. (continued on next page)

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F 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A phone interview was conducted with the Former Administrator on 12/12/24 at 8:59 AM. He stated the BOM notified him on 5/10/24 that she reviewed Resident #70's bank account transaction records and identified concerns related to mobile payment application withdrawals made by Housekeeper #1. He revealed that Housekeeper #1 was no longer employed at the facility when the concern was identified. He indicated he filed a police report on 5/10/24. He indicated that the police assigned a detective to the case, and records were requested from the mobile payment application company, however they informed the police they had no records of Housekeeper #1's account. He stated the detective informed him on 5/30/24 that Resident #70's bank account records did not provide enough evidence to file charges against Housekeeper #1, and they would be closing the case. A phone interview conducted with the Detective on 12/16/24 at 9:11 AM indicated the facility filed a police report on 5/10/24 related to Housekeeper #1 setting up a mobile payment application account linked to Resident #70's debit card without his knowledge or permission. He stated the facility provided Resident #70's bank account records which he reviewed and determined there was enough evidence to open a case. He indicated he obtained a search warrant requesting the mobile payment application company release the records of Housekeeper #1's account, however they informed him there was no record of the account. The Detective revealed that without records from Housekeeper #1's mobile payment application account there was not sufficient evidence to file charges and the case was closed. The Administrator was notified of immediate jeopardy on 12/11/24 at 10:52 AM. The facility provided the following corrective action plan: Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 05/10/2024, the Business Office Manager obtained bank statements for Resident #70 and identified on the bank statements that Housekeeper #1 transferred no more than $3,963.15 through a money transfer application from Resident #70's bank account to Housekeeper #1's phone application between 02/05/2024 - 04/08/2024. Housekeeper #1 no longer worked at the facility effective 03/07/2024. The facility recognized that residents who manage their own personal funds have the potential to be affected by the noncompliance of misappropriation of resident property. On 05/13/2024, the Business Office Manager, with consent from Resident #70, requested a direct deposit for Resident #70's Social Security checks into his RFMS (Resident Fund Management System) account. Beginning on 06/03/2024 Resident #70's Social Security checks were direct deposited into his resident trust account managed by the facility. RFMS is a complete resident fund accounting system for handling resident funds, to provide banking solutions, such as direct deposit and direct debits. The Executive Director reported the misappropriation of Resident #70's property to local law enforcement on 05/10/2024. The Executive Director filed the initial allegation to the State agency on 05/30/24. (continued on next page)

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F 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 05/24/2024, Resident #70 was seen by the psychiatric nurse practitioner, the progress note indicated Resident #70 denied feeling depressed, anxious, and stated Resident #70 left his room to socialize with others. He continued to be followed by psychiatric services. Resident #70's liability from June 2024 through December 2024 with a total balance of $628 has been written off without any penalty to the resident. The decision was made by the Regional Business Office Manager to write off the balance on 5/21/2024. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: The Business Office Manager audited the current Resident Financial Management System (RFMS) on 05/15/2024 to ensure no unauthorized activity had occurred. No discrepancies or suspicious activity were identified. Also, during this time no concerns were noted by any other residents/responsible parties regarding unauthorized activity with their personal banking accounts. No other residents/responsible parties reached out to the business office for additional assistance with their personal banking accounts. The Business Office Manager reconciled the asset account (bank account and register statement balance) to the resident trust fund liability account (balance of residents account in the RFMS) to verify the accounts monthly. All disbursements made from the Resident Trust Fund must be documented with a properly signed withdrawal ticket. The facility maintains a pre-numbered withdrawal book with withdrawal tickets in a triplicate to record the disbursements made from the Resident Trust account. A Resident Trust fund statement is mailed to the patient and or Guardian/Responsible Party quarterly. The statement included all accounting transactions to include debits and credit. This process pertains to interviewable and non-interviewable residents with RFMS accounts. On 05/30/2024, the Social Worker interviewed alert and oriented residents to ensure no employee had asked any resident for money or use of their debit, credit, EBT (food stamps) and or Ucard (United Healthcare debit card). No issues or concerns identified. The RFMS reconciliation process was utilized for the non-interviewable residents. Staff were interviewed regarding misappropriation of resident property by the Executive Director and/or Director of Nursing on 05/30/2024. No concerns identified. Address the measures put into place or systemic changes made to ensure that the deficient practice will not occur: (continued on next page)

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F 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Executive Director and/or Director of Nursing re-educated current staff including contracted staff with validation of understanding on the Abuse Policy with emphasis on misappropriation of resident property, unauthorized use of a resident's debit, credit, EBT and or UCard for personal use or gain on 05/30/2024 - 06/05/2024. Education also included the use of a sign out sheet for snacks and drinks purchases. The form included date, name, items purchased, amount given by the resident to the staff, amount returned to the resident, staff signature, resident signature, and a place to have two staff sign if the resident is unable to sign. The snacks and drinks form is located at the nursing station and is reviewed weekly by the Director of Nursing for accuracy to ensure the amount of money given by the resident to the staff minus the item purchased equals the amount of money returned to the resident. Newly hired staff will be educated in orientation. Staff were educated to not accept debit cards from residents for vending machine purchases on 06/05/2024. The Executive Director verbally educated Residents educated the use of debit cards by staff is not allowed for vending machine purchases on 06/05/2024 via room to room. Residents are made aware upon admission and throughout their stay of having the option to secure valuables. The Maintenance Director handled the request of a resident's need for a lock on their nightstand. A key is provided by the Maintenance Director and/or Executive Director. In the event the nightstand does not have locking capabilities, the Maintenance Director will install a lock and provide the key to unlock the nightstand to the resident and the spare key is in a locked box / drawer in the Maintenance Directors office. All residents/responsible parties were offered a RMFS account upon admission and can make changes any time during their stay with consent to the business department. Address how the facility will monitor its corrective actions to ensure the deficient practice will not recur: On 06/05/2024, the Executive Director held an ADHOC Quality Assurance Performance Improvement meeting. The Executive Director presented the deficient practice of misappropriation of resident property and implemented a plan of action to include quality improvement monitoring and the frequency of monitoring. The Executive Director and/or Director of Nursing to complete quality monitoring of five residents weekly for twelve weeks to ensure residents are protected from misappropriation of personal property. Questions asked of the 5 residents included in the quality monitoring are Do you have any concerns related to your finances to include your debit card, EBT card and/or U card? and Do you know who to report concerns to?. The Business Office Manager reconciled the asset account (bank account and register statement balance) to the resident trust fund liability account (balance of residents account in the RFMS) to verify the accounts monthly. All disbursements made from the Resident Trust Fund must be documented with a properly signed withdrawal ticket. The facility maintains a pre-numbered withdrawal book with withdrawal tickets in a triplicate to record the disbursements made from the Resident Trust account. A Resident Trust fund is mailed to patient and or Guardian/ Responsible Party quarterly. The statement includes all accounting transactions to include debits and credit. This process pertains to interviewable and non-interviewable residents. Members of the Quality Assurance Performance Improvement committee include Executive Director, Medical Director, Director of Nursing, the Manager of Social Services, the Housekeeping Manager, the Business Office Manager, the Human Resources Coordinator, Medical Records Clerk, Central Supply Clerk, Admissions Director, Nurse Managers, Dietary Manager, and the Environmental Services Director. The results of the quality monitoring will be brought to the Quality Assurance Performance Improvement meeting monthly to ensure ongoing compliance for 3 months. Quality Improvement monitoring schedule will be modified based on findings of monitoring. The Executive Director is responsible for overseeing the plan of correction. The center Executive Director alleges compliance 06/06/2024. (continued on next page)

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F 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Alleged date of IJ removal: 06/06/24. Validation of the facility's corrective action plan was conducted 12/17/24 through record review and staff interviews. A review of the resident trust account audits indicated they were completed by the Business Office Manager on 5/15/24 and no concerns or discrepancies were identified. An interview conducted with the BOM revealed she continues to audit and reconcile the resident trust accounts monthly and there have been no discrepancies identified. A review of the facility's monitoring audits conducted 6/6/24 through 8/20/24 revealed 5 alert and oriented residents were interviewed weekly and voiced no concerns related to their finances, misappropriation of their personal property or unauthorized charges on their personal bank accounts. Interviews were conducted with housekeeping, nursing, therapy and dietary staff which indicated they received education on the facility's abuse and reporting policy including misappropriation of resident property. The staff revealed the education also included the procedure to follow if a resident requests assistance with purchasing a snack or drink, which included only using cash (no payment cards), documenting the amount of cash the resident gave them, the item purchased, and the amount of cash returned to the resident. The corrective action plan completion date and IJ removal date of 6/06/24 was validated.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 49160 Based on record review, and staff and Adult Protective Services (APS) Intake Social Worker interviews, the facility failed to file a report with the state agency no later than 24 hours after becoming aware of an allegation of misappropriation of resident property and failed to report the incident to APS for 1 of 3 residents reviewed for abuse (Resident #70). The findings included: A review of the facility's abuse, neglect, exploitation and misappropriation policy and procedure revised 11/16/22 read in part: Reporting/Response: Once an allegation of abuse is reported, the Administrator, as the abuse coordinator, is responsible for ensuring that reporting is completed timely and appropriately to appropriate officials in accordance with Federal and State regulations, including notification of Law Enforcement if a reasonable suspicion of crime has occurred. The Abuse Coordinator will refer any or all incidents and reports of resident abuse to the appropriate state agencies. Resident #70 was admitted to the facility 1/05/24. A review of the police department incident report indicated on 5/10/24 at 11:11 AM they received a report that Resident #70 had money stolen from his bank account. A review of the facility's initial allegation report dated 5/30/24 revealed the facility became aware on 5/29/24 that Resident #70's bank statement had several transactions transferring money from his account to a former employee's (Housekeeper #1) mobile payment application account. The report indicated there was reasonable suspicion of a crime, and the alleged misappropriation of resident property was reported to law enforcement on 5/30/24 however it was not reported to Adult Protective Services. The report was completed by the Former Administrator. An interview with the Business Office Manager (BOM) on 12/11/24 at 11:37 AM indicated she did not recall the date but at the end of April she met with Resident #70 to discuss payment of his monthly bill, and he told her he lost his debit card and needed assistance contacting the bank. She revealed they called the bank a few days later and were informed that Resident #70's account had been overdrawn since January and there were several transactions sending money to a mobile payment application account. She stated she reviewed Resident #70's bank statements on 5/10/24 and there were several transactions sending money to various mobile payment application accounts, one of which was Housekeeper #1's. She indicated she contacted the mobile payment application company, and they informed her Housekeeper #1 had opened an account linked to Resident #70's debit card. The BOM revealed she immediately notified the Former Administrator of the concern, and a police report was filed on 5/10/24. A phone interview was conducted with the APS Intake Social Worker on 12/16/24 at 9:27 AM. She stated they had no record of the facility reporting an incident of misappropriation of property for Resident #70. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A phone interview with the Former Administrator on 12/12/24 at 8:59 AM revealed the BOM was reviewing Resident #70's bank statements and there were several transactions transferring money from his account to Housekeeper #1's mobile payment application account. He stated the BOM notified him of the concern on 5/10/24 and he filed a police report. He further stated he did not submit an initial allegation report within 2 hours because he wanted to investigate it further along with the police to see if it was anything. He revealed Housekeeper #1 was no longer employed at the facility when the concern was identified. He stated he submitted the initial allegation report on 5/30/24 once the police investigation was completed and they determined no charges would be filed against Housekeeper #1. The Former Administrator indicated because the police did not file charges against Housekeeper #1, he unsubstantiated the allegation of misappropriation and did not file a report with APS.

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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** 37280 Based on observations, record reviews, and staff, Resident, Wound Nurse and Medical Director interviews, the facility failed to provide care in a safe manner when a dependent resident (Resident #57) fell off the bed during incontinence care. The facility also failed to provide an environment free from a potential hazard when wound cleanser was left unattended on top of the treatment cart and an unmeasurable amount was ingested by Resident #8. This was for 2 of 4 residents reviewed for accidents. The findings included: 1. Resident #57 was admitted to the facility on [DATE] with diagnoses that included Fredrick's Ataxia (a condition that mainly affects the neuromuscular system and the heart and causes poor muscle control and coordination). A review of Resident #57's admission nursing assessment dated [DATE] indicated she was alert and oriented to person, place, time and situation. A review of a baseline care plan dated 10/28/24 indicated Resident #57 required extensive assistance of one staff for bed mobility, toileting and personal hygiene. A review of Resident #57's medical record revealed an order dated 10/28/24 to x-ray the right ankle. A review of an Incident Report dated 10/28/24 at 3:14 PM completed by Nurse #2 indicated Nurse #2 was notified that Resident #57 was on the floor by Nurse Aide (NA) #3. Upon entering the room NA #2 informed Nurse #2 that she was providing incontinent care to Resident #57 and the Resident rolled out of bed. Resident #57 stated she rolled out of bed but denied hitting her head. The Resident indicated her right ankle was hurting. The report also indicated Resident #57 was alert and oriented to person, place, time and situation. A review of Resident #57's medical revealed the result of the right ankle x-ray dated 10/29/24 was negative for fracture. A review of an Investigative Report: Root Cause Analysis dated 10/29/24 completed by the Director of Nursing revealed Resident #57 was admitted [DATE] at 11:30 AM and fall occurred on 10/28/24 at 3:14 PM. NA #2 was providing incontinent care to Resident #57 and when the NA rolled the Resident onto her side while keeping her left hand on the Resident attempting to remove the soiled brief, Resident #57 rolled off the bed. Therapy to screen for bed mobility. (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 and observation of Resident #57 were conducted on 12/09/24 at 11:29 AM. The Resident was lying in the middle of her bed watching television with her bed up against the wall and without side rails. Resident #57 stated, they let me roll out of bed the first night I got here. Resident #57 explained that the first day she was admitted she was soiled and had to be changed. When Nurse Aide (NA) #2 came to provide care, the NA asked her how many people it took to take care of her and Resident #57 told NA #2 that it only took one person to provide care for her. The Resident continued to explain that when the NA turned her over, she continued to roll over and out of the bed onto the floor. Resident #57 reported she hurt her right ankle, and they obtained an x-ray which showed no fracture. She stated her ankle hurt for a few days and since she was on routine pain medication the pain did not last very long at all. During an interview with NA #2 on 12/10/24 at 3:02 PM the NA confirmed that she was scheduled to work on Resident #57's hall on 10/28/24 and was present when the Resident rolled out of the bed. The NA explained that when she made rounds on Resident #57 on 10/28/24 at the end of her shift the Resident needed to be changed. The Nurse Aide reported that she received a brief report about Resident #57 from the Resident's family member who was with her during her admission and the family reported the Resident was total care. The NA stated she had never worked with Resident #57, so she was going to obtain assistance from another staff member when Resident #57 told her that it only took one person to change her. The NA explained that the Resident had soiled herself, so she gathered her supplies and raised her bed to about waist high and made sure the Resident was in the middle of the bed. She reported she then rolled Resident #57 over onto her left side and crossed her right leg over her left leg and while keeping her hand on the Resident's hip, she pulled the brief out from under the Resident and the Resident continued to roll over off the bed and onto the floor. NA #2 indicated she immediately went around to the other side of the bed and Resident #57 was lying on her left side. The NA asked the Resident if she was hurt, and Resident #57 stated she was not hurt but that she just wanted to get up out of the floor. The NA stated she went to the door and saw Nurse Aide #3 standing in the hallway, so she asked her to come to the room because Resident #57 was on the floor. NA #2 stated NA #3 came into the room and saw that Resident #57 was on the floor and then went and got Nurse #2. NA #2 continued to explain that when Nurse #2 came into the room, she assessed Resident #57 before they transferred her back into the bed where she and NA #3 continued to provide incontinence care for the Resident. NA #2 reported she knew she could review the Resident's care plan to determine how many staff it took to provide care for Resident #57, but the Resident told her it only took one person to provide care for her but in retrospect she should have reviewed the care plan. An interview was conducted with Nurse Aide #3 on 12/10/24 at 4:14 AM. The NA explained that she was standing in the hallway near Resident #57's door when NA #2 hollered for her to come in the room because the Resident had fallen on the floor. The NA stated that when she went into the room and noticed the Resident lying on the floor, she asked her if she was hurt which the Resident denied and stated she just wanted to get out of the floor. NA #3 continued to explain that she went to get Nurse #2 who immediately went to the room and assessed Resident #57 who again reported to the Nurse that she was not hurt. She stated they transferred the Resident back to bed. NA #3 reported she understood that Resident #57 rolled out of bed when NA #2 rolled her over to provide incontinent care. She explained that she often worked with the Resident and one person can provide care for Resident #57 because she can help hold herself over. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345329	A. Building B. Wing	12/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gateway Rehabilitation and Healthcare	2030 Harper Avenue NW Lenoir, NC 28645

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/10/24 at 2:32 PM an interview was conducted with Nurse #2 who explained that she was summoned to Resident #57's room on the afternoon of 10/28/24 and observed the Resident lying on the floor lying on her left side. The Nurse reported she assessed Resident #57, and she had no injuries, but she did complain of pain in her right ankle. The Nurse stated she along with other staff transferred the Resident back to bed where Nurse Aide #2 completed incontinence care. Nurse #2 continued to explain that both Nurse Aide #2 and Resident #57 informed her that the Resident told NA #2 that she could manage the Resident by herself before the NA began to provide the incontinent care. Nurse #2 stated that she reported the fall to the Director of Nursing who obtained an order for an x-ray of her right ankle. An interview was conducted with the Director of Nursing (DON) on 12/11/24 at 10:13 AM. The DON explained that on the afternoon of 10/28/24 Nurse #2 informed her that Resident #57 had rolled off the bed during incontinence care provided by NA #2. Nurse #2 stated she had assessed Resident #57, and her only complaint was right ankle pain, so the DON requested an order for an x-ray which was obtained on 10/29/24 and was negative for fracture. She continued to explain that when she investigated the fall, she had NA #2 explain and demonstrate what happened and the NA indicated when she rolled Resident #57 over onto her side the NA kept her left hand on the Resident's hip and when she removed the brief the Resident rolled off the bed and onto the floor. The DON stated Resident #57 was alert and oriented and told NA #2 that she could do the Resident by herself, but the DON stated she felt that because Resident #57 had poor lower trunk control related to her diagnosis of Fredrick's Ataxia and with the momentum of being turned to her side, she could have kept on rolling. The DON stated in retrospect NA #2 should have obtained assistance from another staff member since it was the NA's first-time taking care of Resident #57. 38515 2. Resident #8 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease, anxiety, major depressive disorder, and adult failure to thrive. A review of Resident #8's quarterly Minimum Data Set assessment dated [DATE] revealed her cognition was severely impaired with no delusions, behaviors, or rejection of care. Resident #8 was coded as having wandering behaviors daily. Resident #8 required supervision with mobility and was coded as using a manual wheelchair for mobility. A review of Resident #8's care plan that was last reviewed on 08/01/24 revealed Resident #8 being at risk for wandering behaviors due to dementia. Interventions included to assess for elopement risk, distract Resident #8 from wandering by offering pleasant distractions, and to attempt to identify pattern of wandering and intervene as appropriate. A review of facility incident and accident logs revealed a report dated 03/11/24 that indicated Resident #8 had obtained a bottle of wound cleanser and ingested an unknown amount. Per the incident report, Resident #8 was assessed along with telephone calls made to her representative, the on-call physician, and poison control. The report stated that Resident #8 was placed on observation and with no negative side effects observed. The report also indicated that Resident #8's confused cognition and wandering behaviors contributed to 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	Review of Resident #8's progress notes revealed a note dated 03/11/24 that read: At approximately [10:15] Resident [#8] picked up a bottle of wound cleaner off of the treatment care and opened it up and drank an unmeasurable amount. Staff immediately obtained the cleaner from the resident and obtained vital signs (blood pressure 141/69, pulse 71, oxygen saturation 98%, respirations 16, and temperature 98.5 [degrees Fahrenheit]. This nurse immediately called on-call clinicians and spoke with physician whom stated to call poison control. This nurse then called poison control . and informed them of the situation. She gave orders to give [Resident #8} one or two sips of water only and give nothing else for one hour and to closely observe [Resident #8] for any drooling, trouble swallowing, or blisters in the mouth or throat. If none of those symptoms occurred after one hour, to go ahead and give one or two more sips of water and resume regularly scheduled food/drinks and medications. If [Resident #8] does exhibit any of the above listed signs and symptoms, then she needs to be sent to the emergency room . This nurse gave detailed instructions to staff and staff are following clinician's instructions. The progress note was written by Nurse #4. Review of the facility's safety data sheet (SDS) for the wound cleanser that was ingested by Resident #8 revealed the following instructions if accidentally ingested: Ingestion - [look for] nausea, vomiting, and diarrhea. Drink water. An interview with Nurse #4 on 12/13/24 at 12:17 PM revealed he was familiar with Resident #8 and described her as very confused with aimless wandering behaviors. He also stated he remembered the incident and stated that two, now unknown, nurse aides came to him that evening with Resident #8 and a bottle of wound cleanser and informed him Resident #8 had ingested an unknown amount of wound cleaner. Nurse #4 stated he immediately assessed Resident #8 and obtained her vitals and did not believe there was anything out of the normal. He continued, stating that he called the on-call physicians who informed him to contact poison control. Poison control suggested that he closely monitor Resident #8 for any vomiting, nausea or the development of blisters in Resident #8's mouth and throat. He stated he then contacted the Director of Nursing and Resident #8's responsible party. Nurse #4 stated he monitored Resident #8 closely for the rest of his shift and did not note any nausea, vomiting, or blisters. He stated when he observed the wound cleanser bottle it did not appear to have much missing and estimated that the bottle was almost full. Nurse #4 reported he was informed that Resident #8 had obtained the bottle of wound cleanser from the wound treatment cart which was kept at the end of a hall near the nurse's station. He stated it was routine for the wound cleanser not to be locked on the wound cart and was either stored in a side pocket or on top of the wound cart. Nurse #4 also reported that, to his knowledge, Resident #8 never had to receive additional medical treatment, in house, or at the hospital due to the ingestion of the wound cleanser. He reported that he had not seen Resident #8 attempt to ingest non-food items before or since the incident. Attempts were made to identify and speak to the unknown nurse aides that brought the incident to Nurse #4's attention but those attempts were unsuccessful. (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 Wound Nurse on 12/11/24 at 2:33 PM revealed she did not know anything about Resident #8 ingesting wound cleanser. She stated if the wound cleanser was ingested it could cause some gastrointestinal discomfort, nausea, and/or vomiting. She stated she was aware Resident #8 had wandering behaviors and admitted to knowledge of Resident #8 having touched things on the cart but denied knowledge of Resident #8 taking anything off of the cart and attempting to or actually ingesting it. The Wound Nurse reported she typically kept wound cleanser on the cart and available for other staff when she was not in the facility. The Wound Nurse reported she stored the wound cleanser either on top of her cart or in a side pocket of the wound treatment cart and not locked away inside the cart. An observation of the wound treatment cart on 12/12/24 at 1:37 PM revealed it was at the end of a hall outside of a resident's room. The room was posted as being on enhanced barrier precautions and the wound cart was outside the room, with the door closed. An observation of the wound cart revealed a bottle of wound cleanser sitting on top of the wound cart with the top unscrewed. There were no observed residents around the wound cart. An interview with the Director of Nursing on 12/12/24 at 1:52 PM revealed she was familiar with Resident #8 and that she was severely cognitively impaired and had wandering behaviors. She stated in March, she was made aware of an incident by Nurse #4 regarding Resident #8 ingesting an unknown amount of wound cleanser. She stated poison control was contacted but reported she did not believe they instructed the staff to do a whole lot. She indicated Resident #8 was monitored and given a few sips of water. The Director of Nursing reported Resident #8 had no adverse reaction to ingesting the wound cleanser. She reported the administrative staff discussed the incident in their interdisciplinary team meeting but could not recall if they implemented any additional care plan interventions or policies to help keep the incident from happening again. She stated wound cleanser should always be kept locked away to prevent residents from accessing it, and that nothing should be stored in the side pockets or on top of the wound treatment cart. An interview with the Medical Director on 12/11/24 at 2:33 PM revealed he had taken over as the medical director in August and was not aware of the Resident #8 ingesting wound cleanser. He reported there was always a potential concern with a resident ingesting wound cleanser and stated he would expect the staff to closely monitor the resident post ingestion for metabolic and other issues which included vomiting, diarrhea, or changes in their general condition. He did report small doses would not necessarily be concerning.