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	345131	A. BUILDING _____ B. WING _____	C 02/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CLEMMONS	3905 CLEMMONS ROAD CLEMMONS, NC 27012

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E 001 SS=F	Establishment of the Emergency Program (EP) CFR(s): 483.73 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop and maintain a comprehensive Emergency Preparedness (EP) -program which contained the required information to meet the health, safety and security needs of the resident population and staff. This failure had the potential to affect all	E 001	Accordius Health at Clemmons POC Deficiency Statement: Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or	3/24/20

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

Electronically Signed | 03/18/2020

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.

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E 001	Continued From page 1 residents and staff. Additionally, the EP plan had not been updated at least annually. Findings included: 1. The facility's Emergency Operations & Recovery Plan dated 2020 was review on 2/27/20. This review revealed the facility's EP plan did not contain the following required information: A. The LTC (Long Term Care) facility did not develop and maintain an EP plan that was reviewed and updated at least annually. The EP plan did not address the resident population including at risk residents and the type of services the facility could provide in an emergency. B. The EP plan was not annual updated to include a documented, facility-based risk assessment utilizing an all-hazards approach, including missing residents. Nor comprehensive strategies for addressing emergency events identified by the risk assessment. C. The EP plan did not address a procedure for tracking residents and on-duty staff if evacuated during an emergency. D. The EP plan did not address patient/client population, including, but not limited to, persons at-risk; the type of services the LTC facility could provide in an emergency; and continuity of operations, including delegations of authority and succession plans. E. The EP plan did not include a process for cooperation and collaboration with local, tribal, regional, State, and Federal EP officials' efforts to	E 001	conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law. E001 Based on record review and staff interviews the facility failed to develop and maintain a comprehensive Emergency Preparedness (EP) program which contained the required information to meet the health, safety, and security needs of the resident population and staff. This failure had the potential to affect all residents and staff. Additionally, the EP plan had not been updated at least annually. Address how corrective action will be accomplished for those residents found to have been affected or have the potential to be affected by the deficient practice; " The Regional Director of Operations re-educated the Administrator on the development of a comprehensive EP plan which described the facilities comprehensive approach to meeting health, safety and security needs for their staff and resident population during an emergency or disaster situation. (Completion 3/17/20) " On 3/17/20, the Administrator and Maintenance Director began development of a comprehensive EP plan which describes the facilities comprehensive approach to meeting health, safety and security needs for their staff and resident	

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E 001	Continued From page 2 maintain an integrated response during a disaster or emergency, including documentation of the LTC facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. F. The EP plan did not contain the role of the facility using a waiver declared by the Secretary, in accordance with section 1135 of the Act. G. The EP plan did not address the subsistence needs for staff and residents that included at a minimum, (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. (b) Policies and procedures. LTC facilities must develop and implement EP policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures were not reviewed and updated at least annually. H. The EP plan did not address a means to shelter in place for patients, staff, and volunteers who remain in the LTC facility.	E 001	population during an emergency or disaster situation. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur; " The facilities EP plan addresses the facility□s resident population, processes for EP collaboration, subsistence needs for staff and residents, procedure for tracking staff and residents, policies and procedures for medical records, policies and procedures for volunteers, arrangement with other facilities, development of a communication plan, names and contact information, emergency officials contact information, primary/alternate means for communication, methods for sharing information, sharing information on occupancy/needs, EP training and emergency power. " The plan will be reviewed annually by the Administrator and Maintenance Director, in conjunction with the Interdisciplinary Team (IDT). Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. The PoC is integrated into the quality assurance system of the facility. " The Regional Director of Operations will review the facility EP plan to ensure	

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E 001	Continued From page 3 I. The EP plan testing exercises did not include a second full-scale exercise that was community or facility based and did not include a tabletop exercise with analysis. J. The EP plan did not address a system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. K. The EP plan did not address the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. L. The EP plan did not address the role of the LTC facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. M. The EP plan did not address the LTC facility to develop and maintain an EP communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. N. The EP plan did not address training and testing. The LTC facility did not develop and maintain an EP training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and	E 001	the facility plan includes a comprehensive approach to meeting health, safety, and security needs for their staff and resident population during an emergency or disaster situation. " The facility plan will include: o Current facility risk population identified, including residents needing special care like oxygen and immobility and services the facility can provide residents during an emergency situation. o Collaboration with local, federal and state EP officials. o Process to track staff and residents if displaced. o Shelter in place criteria for residents and/or staff who need to remain in the facility in the event evacuation could not occur. o Maintaining confidentiality of resident medical records during an evacuation or transfer to another facility, during an emergency. o Process to utilize volunteers. o Transfer arrangements with other facilities. o A defined role under a waiver declared by the secretary. o Communication Plan, including name, contact information for all staff working in the facility, contact information of resident□s attending physician, and contact information of facilities available to provide care and services to residents in an emergency. o To include emergency officials□ contact information. o Communication plan to include how resident information and medical	

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E 001	Continued From page 4 the communication plan at paragraph (c) of this section. The training and testing program were not reviewed and updated at least annually. O. The EP program did not: (ii) Provide EP training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. P. The facility did not conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. Nor did the facility: (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed. During an interview with the Acting Administrator on 2/27/2020 at 12:15pm, he indicated that he was only here for this survey. The Administrator was on vacation during this survey. The Acting Administrator indicated that the facility's EP Book was still in progress. He also indicated that he saw an old EP book down in the Administrator's office. Acting Administrator indicated he was unaware if the facility's EP plan contained all the required information needed.	E 001	documents will be shared with other facilities and health care providers to ensure continuity of care. o To include communication of available beds. o Communication plan to include how emergency plan information that is shared with facilities residents, family members and resident□s representative. o A process for testing and training requirements of this plan. o To include integrated health system polices. o Identified emergency power system that is in place in case of a power failure during an emergency. " The facilities plan will be reviewed biannually until the next annual recertification survey. The Quality Assurance Committee will reevaluate and determine if any changes need to take place or if continued monitoring will be needed after 6 months.	

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E 001	Continued From page 5 At 1:30pm on 2/27/2020 the Acting Administrator revealed an Emergency Operations & Recovery Plan (EOP) dated February 2020. The facility's EOP Template and the information for this template was not completed.	E 001		
F 000	INITIAL COMMENTS A recertification and complaint survey was conducted from 2-23-20 to 2-28-20 Event ID # 1V5411. 1 of the 10 complaint allegations were substantiated resulting in deficiencies.	F 000		
F 561 SS=E	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the	F 561		3/24/20

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F 561	Continued From page 6 facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interview the facility failed to provide residents a shower according to their preference and schedule. This was evident for 4 of 8 residents reviewed for choices (Resident #36, Resident #16, Resident #30 and Resident #132). The facility additionally failed to get a resident out of bed as she requested (Resident #232). Findings Included: 1. Resident #36 was admitted to the facility on 12/3/19 and diagnoses included congestive heart failure, diabetes, peripheral vascular disease and difficulty walking. A care plan dated 12/22/19 for Resident #36 stated he had a self-care performance deficit related to decreased mobility, poor circulation, poor coordination and balance due to bilateral lower extremity weakness with chronic degenerative back disease. The goal was the resident would improve his current level of function through the next review date and an intervention stated he required assistance by one staff member with bathing and showering. A quarterly minimum data set (MDS) assessment dated 2/10/20 for Resident #36 identified his cognition was intact, he was totally dependent on	F 561	F561 Based on observations, record review, resident and staff interview the facility failed to provide residents a shower according to their preference and schedule. This was evident for 4 of 8 residents reviewed for choices (Resident #36, Resident #16, Resident #30 and Resident #132). The facility additionally failed to get a resident out of bed as she requested (Resident #232). Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; • Residents # 36, 16, 30, and 132 were promptly given a shower. (Completion 2/28/20) • Resident #232 was promptly assisted out of bed and dressed. (Completion 2/28/20) • All Licensed Nurses, Certified Medication Aides (CMA's), and Certified Nursing Aides (CNA's) were educated on Resident Self-Determination; that every	

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F 561	Continued From page 7 staff for bathing and had no behaviors identified during the look-back period. An interview with Resident #36 on 2/23/20 at 11:20 am revealed he hadn ' t had a shower in two weeks. The resident explained he had told some of the nurses and someone in the office (he did not recall the names or dates) about not receiving a shower and they told him they would have the staff give him a shower, but they never did. He stated he went out to the wound center every week and he didn ' t want to go there smelling. The resident added he believed he told the Director of Nursing (DON) about his concern, but he still hadn ' t received a shower. Review of the shower schedule for Resident #36 identified his shower days were Tuesdays, Thursdays and Saturdays on first shift. An interview with the Social Worker (SW) on 2/26/19 at 1:09 pm revealed Resident #36 had not expressed any concerns to her about not receiving his showers. An interview on 2/26/20 at 10:29 am with Nursing Assistant (NA) #4 revealed she had worked with Resident #36 but had not provided him with showers. She added his shower days must not have been scheduled for the days she worked with him. An interview on 2/26/20 at 2:00 pm with the DON revealed the Nursing Assistants (NAs) were supposed to document when the resident received a shower in the task section of the electronic medical record. Review of the shower documentation for Resident #36 revealed the resident had not received his showers as	F 561	resident has the right to and the facility must promote and facilitate resident Self-Determination through support of resident choice. Nursing staff were also educated on the significance of Care Planning resident choices as a guide to ensure that the facility is caring for residents in a manner that is significant to the resident. (Completion 03/11/20) Address how corrective action will be accomplished for those residents having a potential to be affected by the same deficient practice; • DON and/or designee will be responsible for creating a shower schedule for all residents residing in the facility. This shower schedule will be maintained at each nurses station and will be revised periodically according to resident preferences. o The schedule will be checked off as each resident receives their shower. (Completion 03/20/20) • Social Work Director and/or Assistant Social Work Director will conduct an initial audit by conducting interviews of all residents of the facility to identify the residents' preferences for getting out of bed. o The Social Services Department will ensure residents preferences for getting out of bed are included in the care planning process. • DON and/or designee, in conjunction with the Social Services Department, will	

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F 561	Continued From page 8 scheduled. The DON explained most residents were scheduled to have 2 to 3 showers a week and some residents had voiced concerns to her that they were not given their showers as scheduled. She stated she expected the resident ' s showers to be given as scheduled and documented. She added if the resident refused the shower the NA should notify the Nurse. An interview on 2/27/20 at 1:53 pm with the Interim Administrator revealed he expected all residents to receive their showers according to the schedule and their preference. 2. Resident #16 was admitted to the facility on 9/11/17 and diagnoses included cerebral palsy and epilepsy. A care plan dated 11/14/17 for Resident #16 stated she required assistance with activities of daily living (ADL ' s) related to impaired mobility and weakness secondary to spastic hemiplegia, seizure disorder and cerebral palsy. The goal was the resident would maintain ADL performance through the next review and intervention stated to provide total assistance with one staff member with bathing and showering. A quarterly minimum data set (MDS) assessment dated 1/1/20 for Resident #16 revealed her cognition was intact, she required one-person physical assist / transfer with bathing and had no behaviors identified for the look-back period. An interview on 2/24/20 at 10:12 am with Resident #16 revealed she hadn ' t had a shower since last Tuesday and she wanted to receive her showers regularly.	F 561	be responsible for creating a schedule for residents who prefer to get out of bed. This schedule will be maintained at each nurses station and will be revised periodically according to resident preferences. o The schedule will be checked off as each resident is promptly assisted out of bed on a daily basis for 30 days. o A random audit of resident preferences will be conducted by the DON and/or designee on a weekly basis for 60 days. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur; • All Licensed Nurses, Certified Medication Aides (CMA's), and Certified Nursing Aides (CNA's) were educated on Resident Self-Determination; that every resident has the right to and the facility must promote and facilitate resident Self-Determination through support of resident choice. Nursing staff were also educated on the significance of Care Planning resident choices as a guide to ensure that the facility is caring for residents in a manner that is significant to the resident. (Completion 3/18/20) • Schedules will be implemented to ensure that Residents receive their showers promptly and are assisted out of bed according to their preferences. • Activities Director and/or the Assistant Activities Director will survey residents as	

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F 561	Continued From page 9 Review of the shower schedule revealed Resident #16 was scheduled to receive a shower on Mondays, Wednesdays and Fridays on second shift. An interview on 2/26/20 at 12:19 pm with Nursing Assistant (NA) #3 revealed she had given the resident a shower yesterday. NA #2 stated she didn ' t have this assignment that often and wasn ' t sure why the resident hadn ' t received her shower. She added all residents should receive their showers according to the shower schedule. An interview on 2/26/20 at 2:00 pm with the DON revealed the Nursing Assistants (NAs) were supposed to document when the resident received a shower in the task section of the electronic medical record. Review of the shower documentation for Resident #16 revealed the resident had not received her showers as scheduled. The DON explained most residents were scheduled to have 2 to 3 showers a week and some residents had voiced concerns to her that they were not given their showers as scheduled. She stated she expected the resident ' s showers to be given as scheduled and documented. She added if the resident refused the shower the NA should notify the Nurse. An interview on 2/27/20 at 1:53 pm with the Interim Administrator revealed he expected all residents to receive their showers according to the schedule and their preference. 3. Resident #30 was admitted to the facility on 2/6/18 and diagnoses included congestive heart failure and epilepsy.	F 561	part of monthly Resident Council to ensure resident preferences, specifically pertaining to showers and assistance out of bed are promoted by the facility. o Grievances/Concerns will be documented and logged for residents experiencing a lack of self-determination as a result of the facility not promoting self-determination. These grievances/concerns will be remedied immediately. • The Social Services Department will also ensure that resident preferences are promoted by the facility as part of the Care Plan process. • Issues identified by Nursing Staff, Social Services, and the Activities departments will be discussed daily (Monday-Friday) during the morning interdisciplinary team meeting. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented, and the corrective action evaluated for its effectiveness. The PoC is integrated into the quality assurance system of the facility. • DON and/or designee, in conjunction with the Social Services Department, will be responsible for creating a schedule for residents who prefer to get out of bed. This schedule will be maintained at each nurses station and will be revised periodically according to resident preferences. o The schedule will be checked off as	

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A care plan dated 11/16/18 for Resident #30 stated she required assistance with activities of daily living (ADL ' s) related to impaired mobility. The goal was the resident would maintain current level of ADL performance through the next review and intervention stated to provide bed baths in between shower schedule.

An annual minimum data set (MDS) assessment dated 1/3/20 for Resident #30 identified her cognition was intact, she required one-person physical assist / transfer with bathing and had no behaviors identified for the look-back period.

An interview on 2/23/20 at 2:50 pm with Resident #30 revealed she had not had a shower since last Tuesday. The resident stated she didn ' t know why, but she was supposed to have 2 to 3 showers a week.

Review of the shower schedule for Resident #30 identified she was supposed to have a shower on Mondays, Wednesdays and Fridays on first shift.

An interview on 2/26/20 at 12:19 pm with Nursing Assistant (NA) #3 revealed Resident #30 received a shower yesterday. NA #3 stated she didn ' t know why the resident had not been given her showers as scheduled, but the shower schedule should be followed.

An interview on 2/26/20 at 2:00 pm with the DON revealed the Nursing Assistants (NAs) were supposed to document when the resident received a shower in the task section of the electronic medical record. Review of the shower documentation for Resident #30 revealed the resident had not received her showers as scheduled. The DON explained most residents

each resident is promptly assisted out of bed on a daily basis for 30 days.
o A random audit of resident preferences will be conducted by the DON and/or designee on a weekly basis for 60 days.
• The results of these audits and monitoring will be submitted to the QAPI Committee monthly for 3 months. The Quality Assurance Committee will reevaluate and determine if any changes need to take place or if continued monitoring will be needed after 3 months.

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were scheduled to have 2 to 3 showers a week and some residents had voiced concerns to her that they were not given their showers as scheduled. She stated she expected the resident ' s showers to be given as scheduled and documented. She added if the resident refused the shower the NA should notify the Nurse.

An interview on 2/27/20 at 1:53 pm with the Interim Administrator revealed he expected all residents to receive their showers according to the schedule and their preference.

3. Resident #232 was admitted to the facility on 2-6-20 with multiple diagnosis that included chronic obstructive pulmonary disease, diabetes with diabetic neuropathy and congestive heart failure.

The Admission Minimum Data Set (MDS) dated 2-9-20 revealed Resident #232 was cognitively intact and needed extensive assistance with one person for bed mobility and dressing, total assistance with 2 people for transfers and total assistance with one person for toileting and personal hygiene.

Resident #232's care plan dated 2-21-20 revealed a goal that the resident would improve her level of functioning with her activities of daily living. The interventions for the goal were in part; encourage the resident to participate with each interaction, physical and occupational therapy evaluations and treatment per physician's order.

During an interview with Resident #232 on 2-23-20 at 9:55am, the resident said she had requested to get out of bed and be washed at

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9:15am (on 2-23-20) and the nursing assistant had told her she would be "right back" but had not come back. Resident #232 also stated "this happens every day. Some days I don't get out of bed because there is not enough help to get me up".

Resident #232 was interviewed again on 2-23-20 at 2:45pm. The resident was noted to be in her night gown and in the bed. The resident stated, "I still have not been washed up or got out of bed yet". Resident #232 said she was "frustrated" because she was in the facility for rehabilitation "and how am I supposed to work on strengthening if they won't get me out of bed?"

An observation and interview were conducted with Resident #232 on 2-24-20 at 11:00am. The resident was noted to be in her night gown and in bed. The resident stated she had requested to get up out of bed and be washed at 9:00am (on 2-24-20) so she could attend her therapy session "but now I have missed it because they would not get me up." Resident #232 explained therapy had worked with her while she was in the bed conducting lower body strengthening.

Resident #232 was observed on 2-25-20 and 2-26-20 out of bed and washed by 11:00am.

Resident #232 was observed on 2-27-20 at 10:25am in the bed with regular clothes on.

During an interview with nursing assistant (NA) #2 on 2-27-20 at 10:30am, the NA stated Resident #232 was not out of bed because therapy wanted to work on transfers. She also stated Resident #232 would request to get out of bed, but she had not heard the resident request a specific time she

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would like to get up. NA #2 said she "tries" to comply with resident requests but that it was determined on the workload and the other needs of the unit if she would be able to honor the residents request. She also said there were times, mostly weekends, when residents were not able to get up because of the workload.

The therapy director was interviewed on 2-27-20 at 11:00am. The therapy director stated Resident #232 was not able to attend therapy in the therapy room on 2-24-20 "because the nursing assistant did not have time to get her up" but the resident had received therapy in the bed for her lower extremities. The therapy director was noted to look back on previous scheduled therapy appointments and stated Resident #232 had not missed any other sessions in the therapy room.

During an interview with the physical therapy assistant (PTA) for Resident #232 on 2-27-20 at 11:45am, The PTA said she had requested for the nursing assistant to get Resident #232 out of the bed for her therapy appointment on 2-24-20 but was informed by the nursing assistant "she did not have time to get the resident out of bed."

An attempt was made on 2-27-20 at 11:21am, 11:44am and 11:50am to contact the nursing assistant who worked 2-24-20 with Resident #232 but was unable to reach her.

During an interview with the Administrator and interim Director of Nursing on 2-27-20 at 1:06pm, the interim Director of Nursing said staff should be getting the residents out of bed and if the nursing assistant did not have time then they should ask for help from one of their team members or management.

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2. Resident #132 was admitted to the facility on 12/27/2019 with a history of Hypertension, and Muscle weakness. The admission assessment of the Minimum data set (MDS) dated 1/2/20 revealed Resident #132 was cognitively intact. The assessment further indicated that Resident #132 required supervision with personal hygiene and physical help limited to transfer from 1-person assistance with bathing and she had not displayed any behavior of rejection to care. The assessment further indicated that it was very important for her to choose between a tub, shower, bed bath or sponge bath.

The shower book was reviewed and the shower schedule for Resident #132 was Monday Wednesday and Friday.

On 2/23/20 at 11:20 AM an interview was conducted with Resident #132. She stated she had not had a shower since admission to the facility in December 2019. She stated the staff had offered her a shower one day about 3 weeks ago, but she declined due to not feeling well on that day. She stated she had not been offered a shower since that day. She stated when she asked staff about getting a shower, they would become annoyed with her.

The December 2019, January and February 2020 shower documentation for Resident #132 were reviewed and indicated that a shower was not provided to Resident #132.

An interview was completed on 2/25/20 at 3:15 PM with NA #1 and she stated she does not usually take care of resident; however, she would give Resident #132 a shower today. She stated shower sheets were in a book behind the nurse's

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station and should be signed off when a shower is given to a resident. She stated she was not sure why Resident #132 had not received a shower.

On 2/25/20 at 3:23 PM an observation was conducted of Resident #132 being assisted by NA #1 during a shower. Resident #132 was able to independently perform shower and wash hair. NA #1 assisted with transfer and holding shower head.

An interview was conducted on 2/25/20 at 3:31 PM with Nurse #1. She stated she has worked in facility for 3 weeks, and not received any shower sheets turned in to her.

On 2/25/20 at 7:31 PM interview was conducted with Resident # 132 and she stated she felt much better after her shower and having her hair washed after not having one in 2 months.

On 2/26/20 at 1:47 PM, the interim Director of Nursing (DON) was interviewed. She stated the NAs are supposed to provide showers to residents as scheduled and did not know why Resident #132 had not received a shower. She stated most residents are scheduled for 2 to 3 showers a week and the NAs possibly didn't document the shower given. She stated there had been some concerns voiced from residents that showers were not given as scheduled . She added she expected the resident's showers to be given, documented and if refusals should be reported to the nurse.

An interview occurred on 2/27/20 at 1:53 PM with the interim Administrator. He stated he expected all residents to receive their showers according to

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F 561	Continued From page 16 the schedule and their preference.	F 561		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1,	F 584		3/24/20

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F 584	Continued From page 17 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to (1) maintain flooring, window treatments, furniture and closet doors in good repair for 5 of 8 resident rooms (rooms 303, 304, 305, 310 and 312) and the facility failed to (2) maintain a clean living environment for 5 of 8 resident rooms (rooms 303, 304, 305, 307 and 312) observed for environment. Findings included: 1.Observation of hall 300 revealed the facility failed to maintain flooring, window treatments, furniture and closet doors in good repair for the following resident rooms; a. Room 303 was observed on 2-23-20 at 1:56pm and revealed the residents window blinds were broken and the toilet paper holder was loose from the wall. A second observation of room 303 occurred on 2-26-20 at 3:00pm in conjunction with the housekeeping manager and the interim manager for maintenance and revealed the residents window blinds were broken and the toilet paper holder was loose from the wall. The interim maintenance director stated he was unaware of the issues but would have them corrected.	F 584	F584 Based on observation and staff interviews the facility failed to (1) maintain flooring, window treatments, furniture and closet doors in good repair for 5 of 8 resident rooms (rooms 303, 304, 305, 310 and 312) and the facility to failed to (2) maintain a clean living environment for 5 of 8 resident rooms (rooms 303, 304, 305, 307, and 312) observed for environment. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; " Room 303 window blinds were broken and the toilet paper holder was loose from the wall. o Completion □ 3/2/2020 " Room 304 floor tile by the door was cracked and lose and the bottom drawer of the dresser was missing a handle. o Completion □ 2/28/2020 " Room 305 window blinds were broken and there was a drawer missing a handle. o Completion □ 3/2/2020 " Room 310 closet door was broken and leaning against the wall behind the main door. o Completion □ 2/28/2020	

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F 584	Continued From page 18 b. Residents room 304 was observed on 2-23-20 at 3:37pm and revealed the floor tile by the door was cracked and lose and the bottom drawer of the dresser was missing a handle. A second observation of room 304 occurred on 2-26-20 at 3:05pm in conjunction with the housekeeping manager and the interim manager for maintenance and revealed the floor tile by the door was cracked and lose and the bottom drawer of the dresser was missing a handle. The interim maintenance director was interviewed on 2-26-20 at 3:05pm and stated he was unaware of the issues but would have them corrected. He also stated he had put a new system in place for staff to inform maintenance of any issues. He said he had developed a notebook that was kept at every nursing station so staff could write down any issues that needed to be addressed and that he checked the notebook through out the day and signed off on the issue as he had corrected the problem. c. Room 305 was observed on 2-24-20 at 8:49am and revealed the residents window blinds were broken and there was a missing handle on the dresser drawer. A second observation of room 305 occurred on 2-26-20 at 3:10pm in conjunction with the housekeeping manager and the interim manager for maintenance and revealed the residents window blinds were broken and there was a missing handle on the dresser drawer. The interim maintenance director was interviewed on 2-26-20 at 3:10pm and stated he was unaware of the issues but would have them corrected.	F 584	" Room 312 floor tile broken by the bathroom door and the right side of the closet door has a hole approximately 3 inches by 2 inches. o Completion □ 3/2/2020 " Rooms 303, 304, and 307 resident windowsills had a dead wasp, crumbs, and a yellow/orange stains and their wall heating/air units had crumbs and dust in the vent. o Completion □ 3/2/2020 " Room 312 bathroom ceiling vent was covered in dust. o Completion □ 2/24/20 Address how corrective action will be accomplished for those residents having a potential to be affected by the same deficient practice; " A 100% audit of current resident rooms was completed by the Maintenance Director and Assistant Maintenance Director. o Completion □ 3/13/20 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur; " The facility onboarded a new Maintenance Director effective 2/24/20. " The Maintenance Director and Assistant Maintenance Director were educated by the administrator on 3/11/20 about the importance of Maintenance services to maintain a sanitary, orderly,	

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F 584	Continued From page 19 d. Resident room 310 was observed on 2-24-20 at 10:30am and revealed her closet door was broken and leaning against the wall behind the main door. A second observation of room 310 occurred on 2-26-20 at 3:13pm in conjunction with the housekeeping manager and the interim manager for maintenance and revealed her closet door was broken and leaning against the wall behind the main door. The assistant maintenance personal was noted to remove the door from the room and stated on 2-26-20 at 3:13pm that he would have the door repaired. e. Room 312 was observed on 2-24-20 at 10:37am and revealed the floor tile was broken by the bathroom door and the right side of the closet door had a hole in it approximately 3 inches by 2 inches. A second observation of room 312 occurred on 2-26-20 at 3:16pm in conjunction with the housekeeping manager and the interim manager for maintenance and revealed the floor tile was broken by the bathroom door and the right side of the closet door had a hole in it approximately 3 inches by 2 inches. The interim maintenance manager was interviewed on 2-26-20 at 3:16pm and stated he would have the issues corrected. 2. Observation of hall 300 revealed the facility failed to maintain a clean-living environment in the following resident rooms;	F 584	comfortable, and homelike interior. " The Housekeeping supervisor was re-educated by the Administrator on 3/11/2020 about the expectation of daily cleaning and deep cleaning tasks. " A Facility Environmental Rounds Tool will be used by the Maintenance and Assistant Maintenance Director as well as the Environmental Services Director to monitor resident rooms and bathrooms to ensure they are kept clean along with completing any repairs that make the residents environment unsafe, unsanitary, and uncomfortable. These rounds will be completed once a week for 12 weeks, and then monthly for 12 months. The findings from the rounds will be discussed daily (Monday-Friday) during the morning interdisciplinary team meeting. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented, and the corrective action evaluated for its effectiveness. The PoC is integrated into the quality assurance system of the facility. " Maintenance Director, Assistant Maintenance Director and/or Administrator will visually check each resident□s room weekly for 12 weeks and then monthly for 12 months, to ensure they are cleaned (including windowsills), window blinds are operable, vents are crumb and dust free, and all dressers and doors are properly equipped to be risk-free.	

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F 584	Continued From page 20 a. Rooms 303,304, 305 and 307 were observed on 2-23-20 at 1:56pm and revealed the residents' windowsills had a dead wasp, crumbs and a yellow/orange stains and their wall heating/air units had crumbs and dust in the vent. A second observation of rooms 303,304, 305 and 307 occurred on 2-26-20 at 3:00pm in conjunction with the housekeeping manager and the interim manager for maintenance and revealed the residents' windowsills had a dead wasp, crumbs and a yellow/orange stains and their wall heating/air units had crumbs and dust in the vent. The housekeeping manager was interviewed on 2-26-20 at 3:00pm and stated that the housekeeping staff was responsible for cleaning the resident's windowsills and did not know why it had not been cleaned. He also stated the housekeeping staff should report any issues with the wall units to the maintenance department. During an interview with the interim maintenance director on 2-26-20 at 3:00pm he stated he had not received any notice that the wall units needed cleaned but that he would have it completed as soon as possible. b. Room 312 was observed on 2-24-20 at 10:37am and revealed the bathroom ceiling vent was covered in dust. A second observation of room 312 occurred on 2-26-20 at 3:16pm in conjunction with the housekeeping manager and the interim manager for maintenance and revealed the bathroom ceiling vent was covered in dust.	F 584	" The results of all audits and monitoring will be submitted to the QAPI Committee monthly for 12 months. The Quality Assurance Committee will reevaluate and determine if any changes need to take place or if continued monitoring will be needed after 12 months.	

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F 584	Continued From page 21 The housekeeping manager was interviewed on 2-26-20 at 3:16pm and stated housekeeping staff are supposed to clean the bathroom ceiling vents "as they need it" but that he would do an audit of all the other vents to make sure they are being cleaned. During an interview with the Administrator on 2-27-20 at 1:06pm, the Administrator stated he would expect the facility to maintain a clean and safe environment for the residents.	F 584		
F 623 SS=C	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.	F 623		3/24/20

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(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for

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F 623	Continued From page 23 the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and Ombudsman interview, the facility failed to provide written notification to the resident, resident's representative and the Ombudsman when the facility-initiated a transfer or discharge of a resident from the facility. This was evident for 1 of 3 residents reviewed for facility-initiated	F 623	F623 Based on record review, staff interview, and Ombudsman interview, the facility failed to provide written notification to the resident, residents representative and the Ombudsman when the facility-initiated a	

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F 623	Continued From page 24 discharges and transfers (Resident #81). Findings included: Resident #81 was admitted to the facility on November 5, 2019. Review of Resident #81 admission Minimum Data Set (MDS) dated November 12, 2019 revealed that Resident #81 was assessed with severely impaired cognition. She was unable to make daily decisions. The departmental notes revealed Resident #81 was discharged home on December 14, 2019. Further review of the resident's medical record revealed no written notice of the resident's discharge was provided to the Ombudsman or resident representative prior to or after being discharged home. An interview on February 27, 2020 at 8:10am with the Social Worker (SW) revealed she had not sent the resident transfer / discharge list to the Ombudsman. However, the SW stated on 2/25/2020, she emailed the Ombudsman her a 90 day discharge list and thought this was an acceptable time frame for the list to be sent to the Ombudsman. The SW stated the facility had not been completing written notification to the resident or the resident's representatives when they were transferred or discharged. The SW confirmed Resident #81's December 14, 2019 discharge to her home was a facility-initiated transfer and written notification was not provided to the resident's Responsible party. During an interview with the Ombudsman on February 28, 2020 at 9:30am, She revealed that	F 623	transfer or discharge of a resident from the facility. This was evident for 1 of 3 residents reviewed for facility-initiated discharges and transfers (Resident #3). Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; " On 2/25/20, the facilities Social Worker provided written documentation to the Ombudsman of all facility-initiated transfers/discharges since November 2019. " On 3/11/20, the Social Worker received inservice education by the facilities Administrator to ensure that both comprehend the notification requirements of F623. " All Licensed Nursing Staff, Social Work Director, and the Assistant Social Work Director received education on the notification requirements of F623, to ensure that all Licensed Nursing Staff comprehend that all responsible parties be notified when the facility initiates a transfer/discharge. (Completion 3/11/2020) Address how corrective action will be accomplished for those residents having a potential to be affected by the same deficient practice; " On 3/11/20, the Social Worker received inservice education by the facilities Administrator to ensure that both comprehend the notification requirements of F623. " All Licensed Nursing Staff received education on the notification requirements	

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F 623	Continued From page 25 she had been the facility's Ombudsman since November 2019. She stated, she had not received any written documentation from this facility regarding when residents were discharged or transferred until February 25, 2020 when she received a resident transfer and discharge list from the facility's SW. An interview with the Administrator on February 27, 2020 at 3:10 pm revealed the facility did not have any documentation that the resident and their responsible party were notified in writing when they were transferred. He stated his expectation was the Social Worker and staff would follow the regulations for discharging residents from the facility.	F 623	of F623, to ensure that all Licensed Nursing Staff comprehend that all responsible parties be notified when the facility initiates a transfer/discharge. " Social Work Director and/or Assistant Social Work director will audit all facility-initiated transfers/discharges daily for 30 days and then weekly for 60 days to ensure that proper notification requirements were provided. " Social Work Director and/or Assistant Social Work director will provide written documentation of all facility-initiated transfers/discharges monthly to the facilities ombudsman; will be provided within 5 working days. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur; " Social Work Director and/or Assistant Social Work director will audit all facility-initiated transfers/discharges daily for 30 days and then weekly for 60 days to ensure that proper notification requirements were provided. " Social Work Director and/or Assistant Social Work director will provide written documentation of all facility-initiated transfers/discharges monthly to the facilities ombudsman; will be provided within 5 working days. " Results of the monitoring will be discussed daily (Monday-Friday) during the facilities interdisciplinary team meeting. Indicate how the facility plans to monitor its performance to make sure that	

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F 623	Continued From page 26	F 623	solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented, and the corrective action evaluated for its effectiveness. The PoC is integrated into the quality assurance system of the facility. " The Administrator and Social Services Department will audit all facility-initiated transfers/discharges daily for 30 days and then weekly for 60 days to ensure resident and/or resident representative and Ombudsman are notified. " The results of these audits and monitoring will be submitted to the QAPI Committee monthly for 3 months. The Quality Assurance Committee will reevaluate and determine if any changes need to take place or if continued monitoring will be needed after 3 months.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s).	F 657		3/24/20

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F 657	Continued From page 27 An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interview the facility failed to invite a resident to participate in her care plan meeting. This was evident for 1 of 1 resident reviewed for care plan (Resident #64). Findings Included: Resident #64 was admitted to the facility on 7/19/19 and her diagnoses included chronic obstructive pulmonary disease, congestive heart failure, diabetes and anxiety. A quarterly minimum data set (MDS) assessment dated 2/3/20 identified Resident #64 ' s cognition was intact. An interview with Resident #64 on 2/23/20 at 12:09 pm revealed she did not recall being invited to a care plan meeting or having her plan of care reviewed with her. The resident stated she was her own responsible party. Review of Resident #64 ' s medical record confirmed the resident was her own responsible	F 657	F657 Based on record review, resident and staff interview the facility failed to invite a resident to participate in her care plan meeting. This was evident for 1 of 1 resident reviewed for care plan (Resident #64). Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; • A Comprehensive Care Plan meeting will be held with Resident #64 to ensure she understands and agrees with her plan of care. (Completion 3/20/20) • The Social Work Director and Assistant Social Work Director, in conjunction with the MDS Coordinator, were educated on Comprehensive Care Planning to ensure that all departments comprehend the requirements.	

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F 657	Continued From page 28 party. There was no documentation in the medical record regarding the resident ' s inclusion in her care plan. An interview with the Social Worker (SW) on 2/26/20 at 1:21 pm revealed she did not recall having a care plan meeting with the Resident #64. A follow-up interview with the SW on 2/27/20 at 11:16 am revealed the facility sent letters to the resident and their responsible parties to invite them to their care plan meeting. She explained the letters went out about a week before their scheduled care plan meeting. The SW stated she could not find any information that Resident #64 had been invited to her care plan meeting. She added the resident should have been invited and could not explain why this was missed. An interview on 2/27/20 at 1:57 pm with the Interim Administrator revealed he expected all residents to be invited to their care plan meeting to review their plan of care.	F 657	o Also, to ensure that the departments understand that the resident/resident representative must be afforded advance notice of care planning conferences to ensure resident/resident representative participation. (Completion 03/11/20) Address how corrective action will be accomplished for those residents having a potential to be affected by the same deficient practice; • The Social Work Director and Assistant Social Work Director, in conjunction with the MDS Coordinator, were educated on Comprehensive Care Planning to ensure that all departments comprehend the requirements. o Also to ensure that the departments understand that the resident/resident representative must be afforded advance notice of care planning conferences to ensure resident/resident representative participation. (Completion 03/11/20) • MDS Coordinator will create monthly schedules for Care Plan Conferences and provide those schedules to the Social Services Department. • Social Work Director and/or Assistant Social Work Director will create a standardized invitation letter for all facility Care Plan Conferences. The letter's will be mailed out on a monthly basis to the resident/resident representative, and/or hand delivered by Social Services to the resident. (Completion 2/28/20)	

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F 657	Continued From page 29	F 657		

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur;
• MDS Coordinator will create monthly schedules for Care Plan Conferences and provide those schedules to the Social Services Department.

• Social Work Director and/or Assistant Social Work Director will create a standardized invitation letter for all facility Care Plan Conferences. The letter's will be mailed out on a monthly basis to the resident/resident representative, and/or hand delivered by Social Services to the resident.
(Completion 2/28/20).
• Issues identified by Social Services Department and MDS Coordinator will be discussed daily (Monday-Friday) during the morning interdisciplinary team meeting.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented, and the corrective action evaluated for its effectiveness. The PoC is integrated into the quality assurance system of the facility.
• Care Plan Schedules will be provided to the Administrator on a monthly basis, and confirmation of invitation letters mailed or delivered to the resident will be

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F 657	Continued From page 30	F 657	reviewed with the QAPI Committee monthly for 3 months. The Quality Assurance Committee will reevaluate and determine if any changes need to take place or if continued monitoring will be needed after 3 months.	
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interview, staff interviews and nurse practitioner interview the facility failed to treat 1 of 3 residents (Resident #54) for their general skin condition according to physicians' orders who were reviewed for general skin condition. Findings included: 1.Resident #54 was admitted to the facility on 10-22-19 with multiple diagnosis that included malignant neoplasm of overlapping sites of the rectum, unspecified open wound of the buttocks. The quarterly Minimum Data Set (MDS) dated 1-20-20 revealed Resident #54 was cognitively intact and was coded as having a surgical wound and receiving radiation therapy.	F 684	F684 Based on observation, record review, resident interview, staff interviews, and nurse practitioner interview the facility failed to treat 1 of 3 residents (Resident #54) for their general skin condition according to physicians orders who were reviewed for general skin conditions. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; " Resident #54 immediately received skin care ordered by the physician. The facility confirmed there are no signs and symptoms of infection as a result of this	3/24/20

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F 684	Continued From page 31 Resident #54's care plan dated 2-17-20 revealed a goal that the area to her anus would improve with no signs or symptoms of infection and staff will implement interventions to promote wound healing. The interventions for the goal in part were; encourage good nutrition, treatment as ordered, weekly documentation and weekly measurements. A review of the physician order dated 1-22-20 revealed an order for Resident #54; clean sacrum area with anasept, pat dry, pack with silver alginate, cover with a dry absorptive dressing. Wound care to be completed daily, every day shift. During an interview with Resident #54 on 2-24-20 at 10:43am, the resident stated she was "worried" that she was going to get an infection from her wounds because the staff would not change her dressings on the weekend. She also stated she was "embarrassed" because the wound smelled, and the drainage would seep onto her bedding. Resident #54's Treatment Administration Record (TAR) was reviewed for January 2020 and February 2020 concerning the wound to her sacrum and revealed no documentation that wound care had been completed on the following dates; 1/25/20, 1/26/20, 2/1/20, 2/8/20, 2/9/20 and 2/22/20. Nurse #2 was interviewed on 2-25-20 at 1:53pm. The nurse said the floor nurse was responsible for completing the wound care on the weekends unless it was a weekend she was working and then she would complete the wound care. She also stated she was informed by "some" of the	F 684	deficient practice. " All Licensed Nursing Staff received education on overall Quality of Care to ensure that all residents receive care and treatment enabling them to attain their highest practicable physical, mental, and psycho-social well-being. Address how corrective action will be accomplished for those residents having a potential to be affected by the same deficient practice; " A 100% audit was performed by the DON to identify all residents with skin integrity concerns to ensure they□re receiving skin care in accordance with physician orders. " The DON will review all Treatment Administration records with the Nursing Administration team daily during morning clinical meetings to ensure all residents are receiving quality care in accordance with physician orders. The results of the audits will be maintained for 30 days. " All new physician orders will be reviewed daily by the DON and/or designee to ensure compliance with quality of care. The results of the audits will be maintained for 30 days. " All Licensed Nursing Staff received education on overall Quality of Care to ensure that all residents receive care and treatment enabling them to attain their highest practicable physical, mental, and psycho-social well-being. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur; " The DON will review all Treatment	

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F 684	Continued From page 32 residents that their wound care was not getting completed on the weekends she did not work. Wound care was observed for Resident #54 on 2-25-20 at 1:55pm. The wound care Nurse Practitioner was noted to be present and completed measurements and commented that she believed the wound was improving. The wound was noted not to have any signs of infection and the skin surrounding the wound did not have any redness. During an interview with the wound care Nurse Practitioner (NP) on 2-25-20 at 2:15pm, the NP stated she saw the wound care residents weekly and was unaware that wound care was not being completed on the weekends but that she expected staff to follow the physicians orders and complete the wound care "no matter what day of the week it is." She also stated she had "concerns" if wound care was not being completed as ordered because the residents were at risk for infection, worsening wounds and "overall patient decline." Hall 300-unit manager, nurse #3 was interviewed on 2-26-20 at 2:09pm via telephone. Nurse #3 confirmed she was the nurse working the weekends that there was no documentation on the wound care being completed for Resident #54 and also stated "on the weekends I have to supervise the whole building, complete rounds with the doctor and perform maintenance and housekeeping duties and I can't get everything done so yea wound care was missed." The Administrator and Director of Nursing were interviewed on 2-27-20 at 1:06pm. The Administrator stated he expected staff to follow	F 684	Administration records with the Nursing Administration team daily during morning clinical meetings to ensure all residents are receiving quality care in accordance with physician orders. The results of the audits will be maintained for 30 days. " The DON and/or designee will construct an audit tool to be reviewed daily by the Nursing Administration team to ensure all physician orders are followed and all skin conditions are monitored in conjunction with the Treatment Administration Record. " All new physician orders will be reviewed daily by the DON and/or designee with the Nursing Administration team to ensure compliance with quality of care. The results of the audits will be maintained for 30 days. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented, and the corrective action evaluated for its effectiveness. The PoC is integrated into the quality assurance system of the facility. " The results of these audits and monitoring will be reviewed daily (Monday-Friday) with the interdisciplinary team and submitted to the QAPI Committee monthly for 3 months. The Quality Assurance Committee will reevaluate and determine if any changes need to take place or if continued monitoring will be needed after 3 months.	

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F 684	Continued From page 33 physicians' orders and follow the appropriate wound care protocol for each resident. The Director of Nursing said she did not believe there was a staffing issue because the unit managers have access to the on-call nurse and that the unit managers can utilize the on-call to make sure care was being provided.	F 684		
F 686 SS=E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interview, staff interviews and nurse practitioner interview the facility failed to treat 1 of 3 residents (Resident #7) for their pressure ulcer according to physicians' orders who were reviewed for pressure ulcers. Findings included: Resident #7 was admitted to the facility on 1-2-15 with multiple diagnosis that included pressure ulcer of the sacral region- stage 4.	F 686	F686 Based on observation, record review, resident interview, staff interviews, and nurse practitioner interview the facility failed to treat 1 of 3 residents (Resident #7) for their pressure ulcer according to physicians' orders who were reviewed for pressure ulcers. Address how corrective action will be accomplished for those residents found to	3/24/20

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F 686	Continued From page 34 The quarterly Minimum Data Set (MDS) revealed Resident #7 was cognitively intact and was coded for a pressure ulcer. Resident #7's care plan dated 2-15-20 revealed a goal that the resident would be compliant with wound interventions and would not develop a new pressure ulcer. The interventions for the goal were in part; encourage good nutrition, flowed by wound certified nurse practitioner, dressing changes to coccyx per physician orders and weekly measurements. The physician orders dated 11-28-19 revealed an order for Resident #7 to have wound care to her coccyx; clean with anasept, pat dry, apply collagen silver to wound bed. Change dressing everyday shift. This order was discontinued on 1-15-20. The physician orders dated 1-16-20 revealed an order for Resident #7 to have wound care to her coccyx; clean with anasept, pat dry, apply skin prep and cover with an absorptive dressing. Change dressing everyday shift. This order was discontinued on 2-13-20. The physician orders dated 2-14-20 revealed an order for Resident #7 to have wound care to her coccyx; clean with anasept, pat dry, apply hydrogel and cover with an absorptive dressing. Change dressing everyday shift. This order was discontinued on 2-18-20. The physician orders dated 2-19-20 revealed an order for Resident #7 to have wound care to her coccyx; clean with anasept, pat dry, cover with silver collagen and a dry absorptive dressing.	F 686	have been affected by the deficient practice; • Resident #7 immediately received skin care ordered by the physician. The facility confirmed there are no signs and symptoms of infection as a result of this deficient practice. • All Licensed Nursing Staff received education on overall Quality of Care to ensure that all residents receive care and treatment enabling them to attain their highest practicable physical, mental, and psycho-social well-being. All new nursing staff will receive this education during the orientation/onboarding process to ensure competency. Address how corrective action will be accomplished for those residents having a potential to be affected by the same deficient practice; • A 100% audit was performed by the DON on 3/18/20 to identify all residents with skin integrity concerns to ensure they're receiving skin care in accordance with physician orders and professional standards of practice. • Commencing 3/23/20, the DON will review all Treatment Administration records with the Nursing Administration team daily during morning clinical meetings (Monday-Friday) to ensure all residents are receiving quality care in accordance with physician orders and professional standards of practice. The results of the audits will be maintained daily for 30 days. • All Licensed Nursing Staff received education on 3/18/20 on overall Quality of Care to ensure that all residents receive	

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F 686	Continued From page 35 Change dressing everyday shift. Resident #7 was interviewed on 2-23-20 at 3:43pm. The resident said she had a "sore" on her bottom and that it was "painful" at times. She also stated she was "concerned" because "staff is not changing it like they are supposed to." Resident #7 stated it was "mostly" on the weekends. The Treatment Administration Record (TAR) for Resident #7 was reviewed for January 2020 and February 2020 and revealed no documentation that the resident received wound care on the following dates; 1/3/20, 1/11/20, 1/12/20, 1/15/20, 1/18/20, 1/25/20, 1/26/20, 2/18/20, 2/22/20 and 2/23/20. Nurse #2 was interviewed on 2-25-20 at 1:53pm. Nurse #2 stated the floor nurse was responsible for completing the wound care on the weekends unless it was a weekend she was working and then she would complete the wound care. She also stated the facility had a wound care nurse for the weekends, but the facility discontinued the wound care nurse on the weekends "and now there are issues with wound care getting completed on the weekends." Wound care was observed for Resident #7 on 2-25-20 at 1:37pm. The wound care Nurse Practitioner was noted to be present and completed measurements and commented that she believed the wound was progressing. The wound did not have any signs of infection and the skin surrounding the wound did not have any redness. During an interview with the wound care Nurse	F 686	care and treatment enabling them to attain their highest practicable physical, mental, and psycho-social well-being. All new nursing staff will receive this education during the orientation/onboarding process to ensure competency. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur; • Commencing 3/23/20, the DON will review all Treatment Administration records with the Nursing Administration team daily during morning clinical meetings to ensure all residents are receiving skin treatment in accordance with physician orders and professional standards of practice. The results of the audits will be maintained daily for 30 days. • The DON and/or designee will implement an audit tool on 3/23/20 to be reviewed daily by the Nursing Administration team to ensure all residents identified with pressure ulcers are monitored in conjunction with the Treatment Administration Record. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented, and the corrective action evaluated for its effectiveness. The PoC is integrated into the quality assurance system of the facility. • The results of these audits and monitoring will be reviewed daily (Monday-Friday) with the interdisciplinary	

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F 686	Continued From page 36 Practitioner (NP) on 2-25-20 at 2:15pm, the NP stated she saw the wound care residents weekly and was unaware that wound care was not being completed on the weekends but that she expected staff to follow the physicians orders and complete the wound care "no matter what day of the week it is." She also stated she had "concerns" if wound care was not being completed as ordered because the residents were at risk for infection, worsening wounds and "overall patient decline." Hall 300-unit manager, nurse #3 was interviewed on 2-26-20 at 2:09pm via telephone. Nurse #3 confirmed she was the nurse working the weekends where there was no documentation that Resident #54 received wound care and also stated "on the weekends I have to supervise the whole building, complete rounds with the doctor and perform maintenance and housekeeping duties and I can't get everything done so yea wound care was missed." The Administrator and Director of Nursing were interviewed on 2-27-20 at 1:06pm. The Administrator stated he expected staff to follow physicians' orders and follow the appropriate wound care protocol for each resident. The Director of Nursing said she did not believe there was a staffing issue because the unit managers have access to the on-call nurse and the unit managers can utilize the on-call to make sure care was being provided.	F 686	team and submitted to the QAPI Committee monthly for 3 months. The Quality Assurance Committee will reevaluate and determine if any changes need to take place or if continued monitoring will be needed after 3 months.	
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a	F 688		3/24/20

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F 688	Continued From page 37 resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interview the facility failed to apply a resting hand splint as ordered by the physician. This was evident for 1 of 2 residents reviewed for limited range of motion (Resident #16). Findings Included: Resident #16 was admitted to the facility on 9/1/17 and diagnoses included contracture of the right hand, cerebral palsy and epilepsy. A care plan with an origination date of 11/24/17 for Resident #16 stated the resident had a contracture of her right hand and to provide skin care daily to prevent skin breakdown. Review of the physician ' s orders for Resident #15 identified an order with a start date of 9/10/18 for the resident to wear a right resting hand splint for 4 hours per day.	F 688	F688 Based on observation, record review, resident and staff interview the facility failed to apply a resting hand splint as ordered by the physician. This was evident for 1 of 2 residents reviewed for limited range of motion (Resident #16). Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; • Hand splints were promptly placed on Resident #16 to prevent further deficient practice. (Completion 2/28/20) • All Nursing Staff received education on Mobility to ensure that all residents with a limited range of motion receives appropriate treatment and services to	

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F 688	Continued From page 38 A quarterly minimum data set (MDS) assessment for Resident #16 dated 1/1/20 identified she had an impairment in range of motion to both sides of upper and lower extremities and her cognition was intact. An observation and interview with Resident #16 on 2/24/20 at 10:44 am revealed the resident had contractures of her fingers on her right hand. The resident stated she had a splint for her right hand, but the staff did not put the splint on. An observation of Resident #16 on 2/25/20 at 6:11 am revealed the resident was out of bed and dressed for the day. She did not have the splint applied to her right hand. An interview on 2/26/20 at 12:19 pm with Nursing Assistant (NA) #3 revealed she was not aware Resident #16 had a splint for her right hand. An observation and interview with Resident #16 on 2/26/20 at 12:25 pm revealed the resident did not have a splint on her right hand. The resident obtained the splint out of the drawer and showed the surveyor the splint she was supposed to have applied to her right hand. Resident #16 stated the staff had not helped her put the splint on. The resident could not recall the last day the splint was applied. An interview with Nurse #1 on 2/26/20 at 12:38 pm revealed the resident had a physician ' s order to wear a right-hand splint 4 hours a day. The nurse stated the order did not include any specific direction about who was to apply the splint or what time of day she should have it applied.	F 688	increase range of motion to prevent further decrease in range of motion, and to ensure that all residents receive appropriate equipment and assistance to maintain or improve mobility. (Completion 3/18/20) Address how corrective action will be accomplished for those residents having a potential to be affected by the same deficient practice; • A 100% audit was performed by the DON to identify all residents with limited range of motion to ensure that they have the appropriate equipment and receive the ordered care. • The DON will review all Medication Administration records with the Nursing Administration team daily during morning clinical meetings to ensure all residents are adequately equipped with the appropriate assistive devices to maintain and/or increase range of motion in accordance with physician orders and professional standards of practice. The results of the monitoring will be maintained for 30 days. • All new physician orders will be reviewed daily by the DON and/or designee to ensure compliance with this deficient practice. The results of the monitoring will be maintained for 30 days. • All Nursing Staff received education on Mobility to ensure that all residents with a limited range of motion receives appropriate treatment and services to increase range of motion to prevent further decrease in range of motion, and to ensure that all residents receive appropriate equipment and assistance to	

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F 688	Continued From page 39 An interview on 2/27/20 at 10:41 pm with the Occupational Therapist (OT) revealed she had worked with Resident #16 on and off for about 2 years. She stated the resident ' s primary diagnosis was cerebral palsy and her right hand was contracted. The OT explained she had recommended a splint for her right hand to help the contracture from getting worse. She added when a resident completed therapy, she would provide the NAs both verbal and written instructions on how to apply the splint and the amount of time the resident should wear the splint. The OT indicated in her experience with working with Resident #16 she was very cooperative with her care and the resident would not have refused to have the splint put on. She stated the splint was still appropriate for the resident due to the contracture on her right hand and she would benefit from wearing it. The OT added the facility did not have specific restorative NAs and the NA providing care for the resident would be responsible for putting on the splint. An interview on 2/27/20 at 1:55 pm with the Interim Administrator revealed he expected residents ' splints to be applied according to their plan of care.	F 688	maintain or improve mobility. • (Completion 3/18/20) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur; • The DON will review all Medication Administration records with the Nursing Administration team daily during morning clinical meetings to ensure all residents are receiving quality care in accordance with physician orders. • Daily audits will be conducted for 30 days by the DON and/or designee on residents with a limited range of motion to ensure that residents are receiving appropriate treatment and services to increase range of motion to prevent further decrease in range of motion, and to ensure that all residents receive appropriate equipment and assistance. • All new physician orders will be reviewed daily by the DON and/or designee with the Nursing Administration team to ensure compliance with mobility. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented, and the corrective action evaluated for its effectiveness. The PoC is integrated into the quality assurance system of the facility. • Daily audits will be conducted for 30 days by the DON and/or designee on residents with a limited range of motion to ensure that residents are receiving	

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F 688	Continued From page 40	F 688	appropriate treatment and services to increase range of motion to prevent further decrease in range of motion, and to ensure that all residents receive appropriate equipment and assistance. • The results of these audits and monitoring will be reviewed daily (Monday-Friday) with the interdisciplinary team and submitted to the QAPI Committee monthly for 3 months. The Quality Assurance Committee will reevaluate and determine if any changes need to take place or if continued monitoring will be needed after 3 months.	
F 809 SS=E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced	F 809		3/24/20

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F 809	Continued From page 41 by: Based on observation, record review, staff and resident interviews the facility failed to offer bedtime snacks to 4 of 4 residents reviewed for bedtime snacks (Resident #16, Resident #30, Resident #6, and Resident #63). Findings included: During the resident council meeting that was held on 2/24/2020 at 10:30am, Resident #16, Resident #30, Resident #6 and Resident#63 revealed they each resided on the facility's 300 hallway and they were not being offered bedtime snacks by staff. Observation on 2/25/2020 from 7:00 pm until 9:00 pm of the facility's 300 hallway revealed staff were not offering bedtime snacks to residents. Resident #16 was assessed on her Minimum Data Set (MDS) dated 1/1/2020 as being alert and oriented. During a second interview on 2/25/20 at 8:35pm Resident #16 stated was not offered a bedtimes snack tonight. Resident #16 stated she would love to have a snack tonight. Resident #30 was assessed on her MDS dated 1/3/2020 as being alert and oriented. During a second interview on 2/25/20 at 8:36 pm Resident #30 stated she was not offered a bedtime snack tonight. Resident #6 was assessed on his MDS dated 11/23/2019 as being alert and oriented. During a second interview on 2/25/20 at 8:41pm Resident #6 stated that he was not offered a bedtime snack tonight. Resident #63 was assessed on his MDS dated	F 809	F809 Based on observation, record review, staff, and resident interviews the facility failed to offer bedtime snacks to 4 of 4 residents reviewed for bedtime snacks (Resident #16, Resident #30, Resident #6, and Resident #63). Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; " Nourishing bedtime snacks were promptly prepared, delivered, and offered to all units and residents to remediate this deficient practice. " All Nursing Staff was educated on customer service and meal frequency to ensure that staff comprehends that are not be more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime. Address how corrective action will be accomplished for those residents having a potential to be affected by the same deficient practice; " At bedtime, nursing staff will be required to round each unit and ask all residents if they would like to be served a bedtime snack. An audit tool will be constructed and signed by each Licensed Nurse to ensure all residents are offered a nourishing snack. " The Administrator and/or designee will conduct an audit for a sample of 15 residents weekly for two months and will	

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F 809	Continued From page 42 1/24/20 as being alert and oriented. During a second interview on 2/25/20 at 8:46pm revealed that he was not offered a bedtime snack tonight. Resident #63 revealed that he was hungry and would love to have something to eat tonight. Observation on 2/25/20 from 7:00 pm to 9:00 pm revealed 4 nursing staff were gathered around the Nursing Station on the 300 hallway. During an interview with Nursing Assistant (NA) #3 on 2/25/20 at 8:51 pm he stated that he worked from 7:00 pm until 7:00 am weekly on the 300 hallway. NA #3 revealed he passed out snacks nightly around 9:00 pm. During an interview with NA #4 on 2/25/20 at 8:57 she revealed that she worked from 7:00 pm until 7:00 am, she revealed that she came into work at 7:00pm and she did not see any bedtime snacks to offer to residents. During an interview with the Dietary Manager (DM) on 2/26/20 at 1:20 pm revealed bedtime snacks were prepared daily for all residents, and at 7:00 pm every night snacks are delivered from the kitchen to each unit and nursing staff are responsible for passing them out and offering them to residents on each hall. Interview was conducted on 2/26/20 at 2:30pm with Administrator, he stated bedtime snacks were being sent out by dietary at 7:00 pm nightly. He stated the process was the nursing staff distributed bedtimes snacks after dietary staff delivered them to each hall. He added that all residents should be offered a snack at bedtime.	F 809	present these audits to the daily interdisciplinary team meetings. " All Nursing Staff was educated on customer service and meal frequency to ensure that staff comprehends there are not to be more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur; " At bedtime, nursing staff will be required to round each unit and ask all residents if they would like to be served a bedtime snack. An audit tool will be constructed and signed by each Licensed Nurse to ensure all residents are offered a nourishing snack. " Activities Director and/or the Assistant Activities Director will survey residents as part of monthly Resident Council to ensure residents are offered a nourishing bedtime snack. o Grievances/Concerns will be documented and logged for residents experiencing a lack of customer service and infrequent meal offerings. These grievances/concerns will be remedied immediately. " The Administrator and/or designee will conduct an audit for a sample of 15 residents weekly for two months and will present these audits to the daily interdisciplinary team meetings. Indicate how the facility plans to monitor its performance to make sure that	

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F 809	Continued From page 43	F 809	solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented, and the corrective action evaluated for its effectiveness. The PoC is integrated into the quality assurance system of the facility. " Weekly audits will be conducted for two months for a sample of 15 residents by the Administrator and/or designee to ensure residents are offered a nourishing snack at bedtime. " The results of these audits and monitoring will be reviewed weekly with the interdisciplinary team and submitted to the QAPI Committee monthly for two months. The Quality Assurance Committee will reevaluate and determine if any changes need to take place or if continued monitoring will be needed after one month.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents	F 812		3/24/20

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F 812	Continued From page 44 from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to ensure dishware were clean and dry before being stored; failed to ensure opened food items were sealed, labeled and dated; and failed to discard food before the manufacturer's expiration date. The facility additionally failed to maintain kitchen equipment, ceiling vents and sections of the kitchen walls and ceiling in a clean and operational order. The identified issues had the potential to effect 80 of 81 residents who were served meals at the facility. Findings Included: A kitchen observation was conducted on 2/23/20 starting at 10:20 am. Cook #1 and Dietary Aides #2 and #3 were present during the observation and revealed the following: 1. The storage rack for clean cookware contained 3 half size steam table pans and 3 - 12-quart plastic storage containers that were stacked together wet. There were also 3 third size steam table pans with food particles on the inner and outer surface of the pans. An interview with Dietary Aide (DA) #1 on 2/23/20 at 10:25 am revealed the storage rack was for clean cookware and everything on the rack should be clean and ready to be used. An interview with the Dietary Manager (DM) on	F 812	F812 Based on observation and staff interviews the facility failed to ensure dishware were clean and dry before being stored; failed to ensure opened food items were sealed, labeled and dated; and failed to discard food before the manufacturer’s expiration date. The facility additionally failed to maintain kitchen equipment, ceiling vents and sections of the kitchen walls and ceiling in a clean and operational order. The identified issues had the potential to affect 80 of 81 residents who were served meals at the facility. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; • The storage racks and meal trays were dried promptly, and the unsanitary equipment was promptly cleaned to ensure compliance with this requirement. All expired food was promptly discarded and food/beverages were properly labeled and dated. (Completed 2/23/20) • The Dietary Manager (DM) educated the dietary department on Food Safety Requirements. (Completed 2/23/20)	

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F 812	Continued From page 45 2/25/20 at 7:30 am revealed he had in-serviced the dietary staff on ensuring all cookware and service ware were clean and allowed to air dry before they were stored. 2. 20 of 20 meal trays were stacked together wet on the tray line ready for lunch service. An interview with Dietary Aide #1 on 2/23/20 at 10:25 am revealed the meal trays should have been allowed to dry before they were stored. An interview with the Dietary Manager on 2/25/20 at 7:30 am revealed he had shown the dietary staff how to crisscross the meal trays to allow them to air dry before being stored on the tray line. 3. 2 of 2 plastic sectional plates had food particles present on the inner section of the plates and were stored on the tray line ready for lunch service. An interview with Dietary Aide #1 on 2/23/20 at 10:25 am revealed the sectional plates should be clean before being stored. An interview with the Dietary Manager on 2/25/20 at 7:30 am revealed all service ware should be clean before being placed on the tray line for service. 4. The walk-in cooler contained 2 - 33-ounce containers of apple juice concentrate with an expiration date of 2/6/20 and the tops were covered with a black mold like substance. An open case of thawed ground beef had blood covering the top of the box and was not labeled or dated. A case of thawed chicken was open,	F 812	• The Dietary Manager (DM) was educated by the Administrator to ensure that both DM and Administrator comprehend Food Safety Requirements. (Completed 3/4/20) Address how corrective action will be accomplished for those residents having a potential to be affected by the same deficient practice; • The DM and/or designee will conduct daily audits for wet nesting/air drying and labeling/dating for 30 days to ensure compliance with Food Safety Requirements and ensure the facilities is storing, preparing, distributing, and serving food in accordance with professional standards for food service safety. • The DM will educate the entire Dietary Department on storing, preparing, distributing, and serving food in accordance with professional standards for food service safety on a monthly basis for 12 months. Any Dietary personnel that fails to comply with this education will receive disciplinary action. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur; • The DM and/or designee will conduct daily audits for wet nesting/air drying and labeling/dating for 30 days to ensure compliance with Food Safety Requirements and ensure the facilities is storing, preparing, distributing, and serving food in accordance with professional standards for food service safety. After one month of daily audits,	

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F 812	Continued From page 46 exposed to the air and not labeled or dated. A bag of shredded lettuce approximately 1/4th full was open, exposed to the air with no label or date and the bag was covered in a reddish, brown substance. Several slices of ham were loosely wrapped in plastic wrap, exposed to the air with no label or date. An interview with Cook #1 on 2/23/20 at 10:45 am revealed the chicken and ground beef were placed in the walk-in cooler the previous Wednesday to thaw and some of it had been used since then. He stated the meats should have been dated when they were thawed. Cook #1 explained he didn't know where the blood was coming from on the ground beef, but it needed to be cleaned up. He added all foods should be labeled and dated when opened. An interview on 2/25/20 at 7:30 am with the Dietary Manager revealed all leftover foods should be discarded after 3 days of preparation and foods should be discarded if they were past the expiration date. He explained the beef and chicken had been placed in the walk-in cooler to thaw the previous Thursday and some of it had been used. He added both meats should have been sealed, labeled and dated. The DM indicated all food items should be labeled with a receive date, open date and use by date. He added zipper style bags were available for the staff to store opened food products 5. A cart near the serving line contained an open bag of potato chips, exposed to the air with no label or date. A 5-pound container of grits was open, exposed to the air with no label or date and a 3.5-pound container of instant mashed potatoes was open, exposed to the air with no label or	F 812	the DM will audit Food Safety Requirements (wet nesting/air drying and labeling dating) and processes weekly for three months. • The DM will educate the entire Dietary Department on storing, preparing, distributing, and serving food in accordance with professional standards for food service safety on a monthly basis for 12 months. Any Dietary personnel that fails to comply with this education will receive disciplinary action. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented, and the corrective action evaluated for its effectiveness. The PoC is integrated into the quality assurance system of the facility. • The DM and/or designee will conduct daily audits for wet nesting/air drying and labeling/dating for 30 days to ensure compliance with Food Safety Requirements and ensure the facilities is storing, preparing, distributing, and serving food in accordance with professional standards for food service safety. After one month of daily audits, the DM will audit Food Safety Requirements (wet nesting/air drying and labeling dating) and processes weekly for three months. • The results of these audits and monitoring will be reviewed weekly with the interdisciplinary team and submitted to the QAPI Committee monthly for three months. The Quality Assurance	

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F 812	Continued From page 47 dated. An interview with Cook #1 on 2/23/20 at 10:45 am revealed all foods should be labeled and dated when opened. An interview on 2/25/20 at 7:30 am with the Dietary Manager revealed all food items should be labeled with a receive date, open date and use by date. He added zipper style bags were available for the staff to store opened food products 6. 2 of 2 drip pans located under the range burners and grill had approximately half an inch of black, burnt on food particles and grease. An interview with Cook #1 on 2/23/20 at 10:50 am revealed he believed the drip pans were cleaned about 2 weeks ago. An interview with the Dietary Manager on 2/25/20 at 7:30 am revealed the drip pans should be cleaned after every shift. 7. The walk-in freezer had a significant build-up of ice (thickness of ice varied and was approximately ½ inch to 3 inches) present on multiple cases of food. An Interview with Dietary Aide #1 on 2/23/20 at 10:55 am revealed the ice in the walk-in freezer had been present for several weeks. She explained they tried to keep the food away from the door where the ice was the worst. DA #1 added she believed someone from maintenance had looked at it, but it still wasn't fixed. An interview with the Dietary Manager on 2/25/20	F 812	Committee will reevaluate and determine if any changes need to take place or if continued monitoring will be needed after one month.	

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F 812	Continued From page 48	F 812		

at 7:30 am revealed the ice in the walk-in freezer was coming from the door not sealing correctly; he added it was his understanding the freezer had been serviced multiple times and the door was going to have to be replaced to fix the issue

8. The dish room was observed with Dietary Aide #2 and revealed the top of the dish machine and the garbage disposal were covered in wet, food particles. The table legs were rusted with peeling paint.

An interview with Dietary Aide #2 on 2/23/20 at 11:10 am revealed the dish machine and garbage disposal needed to be cleaned. He added the table legs needed to be replaced.

An interview on 2/25/20 at 7:30 am with the Dietary Manager revealed the dish room including the dish machine and garbage disposal should be cleaned after each meal.

9. 2 of 2 ceiling vents located between the dish room and the tray line were covered in grease and dust.

An interview with the Dietary Manager on 2/25/20 at 7:30 am revealed he had tried to clean the ceiling vents, but it removed all the paint and he felt like these needed to be replaced.

10. The interior of the microwave located on top of the ice machine had food spills and dark colored stains.

An interview with the Dietary Manager on 2/25/20 at 7:30 am revealed the microwave was located in the stairwell with the ice machine and he would need to add this to the dietary cleaning schedule.

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F 812	Continued From page 49 11. The ceiling near the walk-in freezer had a section approximately 2 feet square with water stains. An interview with the Dietary Manager on 2/25/20 at 7:30 am revealed the kitchen walls and ceiling needed to be cleaned and painted. 12. The wall board located across from the cooking equipment contained food spills/splatters. An interview with the Dietary Manager on 2/25/20 at 7:30 am revealed the kitchen walls and ceiling needed to be cleaned and painted. An interview on 2/27/20 at 1:49 pm with the Interim Administrator revealed he expected the kitchen to be kept clean and sanitary. He stated he expected all foods to be sealed, labeled, dated and used within their expiration dates. He added there should be no wet nesting for pots, pans or dishes and they should all be clean and free from food particles. The Administrator added he expected all kitchen equipment to be clean and in good working order.	F 812		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by:	F 867		3/24/20

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F 867	Continued From page 50 Based on observations, staff interviews and record review, the facility's Quality Assessment and Performance Improvement (QAPI) Committee failed to maintain implemented procedures and monitor the interventions that were put in place following the complaint investigation conducted on 11-12-19. This was for a recited deficiency in the area of safe, clean, homelike environment (F584). This deficiency was recited during the facility's annual recertification and complaint survey o 2-28-20. The continued failure of the facility during two federal surveys of record showed a pattern of the facility's inability to sustain an effective QUAPI program. Findings included: This tag was cross referenced to: 1.F584 - Based on observation and staff interviews the facility failed to (1) maintain flooring, window treatments, furniture and closet doors in good repair for 5 of 8 resident rooms (rooms 303, 304, 305, 310 and 312) and the facility failed to (2) maintain a clean living environment for 5 of 8 resident rooms (rooms 303, 304, 305, 307 and 312) observed for environment. During the facility's complaint survey on 11-12-19, the facility was cited for F584 for failing to (1) maintain hand rails, flooring, vents and windows in good repair in the 100 hallway dining room, the 200 hallway and for 2 of 40 resident rooms (rooms 206 and 304), (2) repair/replace lighting in resident rooms for 3 of 40 rooms (rooms 201, 209 and 304), (3) repair walls and ceilings from chipped paint exposing wood and plaster on 100	F 867	F867 Based on observations, staff interviews and record review, the facility□s Quality Assessment and Performance Improvement (QAPI) Committee failed to maintain implemented procedures and monitor the interventions that were put in place following the complaint investigation conducted on 11-12-19. This was for a recited deficiency in the area of safe, clean, homelike environment (F584). This deficiency was recited during the facility□s annual recertification and complaint survey on 02-28-20. The continued failure of the facility during two federal surveys of record showed a pattern of the facility□s inability to sustain an effective QUAPI program. Address how corrective action will be accomplished for those residents found to have been affected or have the potential to be affected by the deficient practice; " The administrator reeducated the Interdisciplinary team (IDT) and members of the Quality Assurance and Improvement Committee regarding accurately reporting and revising current action plans as well as developing and implementing new action plans to assure state and federal compliance in the facility. Completion 3/16/20 " IDT, including the facility Medical Director, will meet at least monthly, effective 3/1/20 to conduct the facility□s Quality Assurance and Performance Improvement meeting. Should any IDT	

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F 867	Continued From page 51 hallway, 300 hallway, 300 hall dining room and 1 of 40 resident rooms (room 201), (4) maintain clean counter tops and microwave in the residents dining room on hall 200. The Administrator and the Regional Corporate Officer were interviewed on 2-27-20 at 2:00pm. The Regional Corporate Officer stated the facility had been working on trying to repair issues in the facility and discussed the facility's plan on painting and repairing wall damage in the resident rooms starting on hall 300. She also stated the facility would continue to make the proper repairs.	F 867	member find that the facility may need an Adhoc Quality Assurance and Performance Improvement meeting for a facility compliance issue, the Administrator will organize a meeting and notify all team members regarding the need to revise any present action plan or for the development of a new action plan to ensure compliance. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur; " The Administrator will develop and maintain an □Administrators Audit Tool□ to ensure that all audits and scope of work to be completed, are completed on schedule. The Administrator will review this tool on a daily/weekly/monthly basis. The Administrator will review the audit tool with IDT daily during morning meetings and monthly with QAPI. " The administrator reeducated the IDT and members of the Quality Assurance and Improvement Committee regarding accurately reporting and revising current action plans as well as developing and implementing new action plans to assure state and federal compliance in the facility. Completion 3/16/20 " IDT, including the facility Medical Director, will meet at least monthly, effective 3/1/20 to conduct the facility□s Quality Assurance and Performance Improvement meeting. Should any IDT member find that the facility may need an Adhoc Quality Assurance and	

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F 867	Continued From page 52	F 867	Performance Improvement meeting for a facility compliance issue, the Administrator will organize a meeting and notify all team members regarding the need to revise any present action plan or for the development of a new action plan to ensure compliance. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. The PoC is integrated into the quality assurance system of the facility. " Quality Assurance monitoring will take place at each Quality Assurance and Performance Improvement meeting monthly and any Adhoc meetings held. This monitoring tool will be signed off by each IDT member after each meeting accepting and acknowledging all monitoring and revisions set forth by the Quality Assurance and Performance Improvement committee.	