STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345131	A. BUILDING ______ B. WING ______	C 09/04/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recerttification, complaint and COVID-19 focused survey was conducted 8/18/20 through 9/4/20. The facility was found in compliance with CFR 483.73 related to E-0024 (b) (6); Subpart B; Regulations for Long Term Care Facilities. Event ID:D86T11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification, complaint and COVID-19 focused infection control survey was conducted 8/18/20 through 9/4/20. The facility was found not to be in compliance with 42 CFR §483.80 infection control regulations. 28 of 61 complaint allegations were substantiated. . Event ID - D86T11	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and	F 550		10/2/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 10/02/2020

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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F 550	Continued From page 1 practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to provide a dignified dining experience by standing over a resident while providing assistance with feeding for 1 of 5 residents (Resident #27) reviewed for dignity. Findings included: Resident #27 was admitted to the facility on 3/24/15 with diagnoses that included, in part, gastroesophageal reflux disease, dysphagia and vascular dementia. The quarterly Minimum Data Set assessment dated 7/1/20 revealed Resident #27 had severe cognitive impairment. She required extensive	F 550	Based on observations, record review, resident and staff interview the facility failed to provide a dignified dining experience by standing over a resident while providing assistance with feeding for 1 of 5 residents (Resident #27) reviewed for dignity. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The Director of Nursing (DON) provided 1:1 education with NA#1 on residents' rights to respect and dignity with meals by maintaining eye level to resident during feeding assistance. Dependent residents requiring assistance	

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F 550

Continued From page 2
assistance with eating.

A nutrition care plan updated 7/27/20 revealed, "assist with meals as needed."

On 8/19/20 at 9:33 AM Resident #27 was observed in her bed with a breakfast tray on her bedside table. Nurse Aide (NA) #1 entered the room and positioned Resident #27 in the bed so that she was in an upright seated position. NA #1 informed the resident what was on the breakfast tray and proceeded to feed Resident #27. NA #1 was standing next to the resident's bed as she provided the resident with feeding assistance. NA #1 stood above eye level of the resident for the duration of the meal while she fed Resident #27. On 08/19/20 at 9:45 AM, NA #1 removed the tray from the resident's room.

An interview was completed with NA #1 on 8/19/20 at 9:45 AM, during which she stated Resident #27 needed to be fed her meal. She explained that she typically stood when she fed a resident and the facility had not educated her on whether to sit or stand when she provided a resident with feeding assistance.

An attempt to interview Resident #27's representative was unsuccessful.

During an interview with the Director of Nursing on 8/21/20 at 12:46 PM, she specified that staff should be seated when they fed a resident.

F 550

with meals will receive respect and dignity during each meal by remaining in a seated position and at eye level with meals and engaging with the resident.
Completed: 8/21/2020
All Licensed Nurses, Certified Medication Aides (CMAs), Certified Nursing Aides (CNAs), were educated by the DON and/or Designee on Residents' rights to respect and dignity with meals by maintaining a seated position at eye level to resident during meal assistance.
Completed: 9/23/2020
Address how corrective action will be accomplished for those residents having a potential to be affected by the same deficient practice:
The DON and/ or Designee will ensure new employees will receive this education as part of orientation process.
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 Director of Nursing and/or Designee will complete quality assurance monitoring by observing five (5) random direct care staff during resident meals that require assistance. Monitoring will be completed five (5) times weekly for four (4) weeks, the weekly for eight (8) weeks and as necessary thereafter. The Administrator will report findings of the monitoring to the IDT during QAPI

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F 550	Continued From page 3	F 550	meetings monthly for three (3) months and will make changes to the plan as necessary to maintain compliance with resident rights to respect and dignity with meals.	
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman	F 583		10/2/20

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F 583	Continued From page 4 to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to ensure privacy during activities of daily living (ADL) care and wound assessment/dressing change for 1 of 3 residents observed for ADL care (Resident #70) and for 1 of 2 residents observed for pressure ulcers (Resident #70). Findings included: Resident #70 was admitted to the facility on 4-25-18 with multiple diagnosis that included dementia with behavioral disturbances, muscle weakness, adult failure to thrive and cognitive communication deficit. The quarterly Minimum Data Set (MDS) dated 7-20-20 revealed Resident #70 was severely cognitively impaired and needed total assistance with one person for toileting and personal hygiene. Resident #70's care plan dated 8-3-20 revealed a goal that he would improve ADL's with therapy and or staff interventions. The interventions for the goal were in part; assist with ADL's to completion and provide incontinence care as needed. During the initial observation of Resident #70's room on 8-19-20 at 10:35am, the observation revealed the room currently had two residents residing in the room and there were no privacy curtains or tracks on which to hang the privacy	F 583	Based on observations, record review, resident and staff interview the facility failed to ensure privacy during activities of daily living (ADL) care and wound assessment /dressing change for 1 of 3 residents observed for ADL care (Resident#70) and for 1 or 2 residents observed for pressure ulcers (Resident#70). During the initial observation of Resident#70s room on 08/19/2020 it was revealed the room currently had two residents residing in the room and there were no privacy curtains or tracks on which to hang the privacy curtains, there was no privacy curtain. 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 to identify rooms without a privacy curtain. Installation of the privacy curtain was completed to ensure residents right to privacy is maintained Completed 9/28/2020 The Administrator Maintenance and Admission Coordinator reclassified room 319 as private. Residents in room 319 were moved to a semiprivate room with privacy curtains for each resident. Completed: 9/23/2020 Address what measures will be put into	

F 583

Continued From page 5

curtains.

On 8-20-20 at 9:52am, observation of ADL care with NA #2 occurred. The observation revealed there were no privacy curtains for the NA to use during her care.

NA #2 was interviewed on 8-20-20 at 9:52am. The NA discussed Resident #70's roommate being present in the room during Resident #70's ADL care and there were no means to provide privacy for Resident #70 during care. NA #2 confirmed there were no privacy curtains or privacy screens available. She also said there had not been any privacy curtains in the resident room "for months."

Observation of Resident #70's wound care occurred on 8-20-20 at 12:15pm with Nurse #3. Resident #70's roommate was observed to be present in the room during Resident #70's entire wound care. The observation revealed Resident #70 had a pressure ulcer on his sacrum and Nurse #3 had positioned the resident, so Resident #70's sacrum was facing his roommate. There were no privacy curtains available for the nurse to use, and Resident #70's roommate had full visual privacy of Resident #70's wound care.

During an interview with Nurse #3 on 8-20-20 at 12:15pm, the nurse stated she tried to shield any visual display of Resident #70's sacrum to the roommate with her body. She also stated she was not sure how long there had not been privacy curtains or why.

The Director of Nursing (DON) was interviewed on 8-21-20 at 12:40pm. The DON said she was aware there were not privacy curtains available in

F 583

place or systematic changes made to ensure that the deficient practice will not occur,

The Director of Nursing Administrative staff and licensed staff provided education to facility staff on maintaining privacy during direct and non-direct care in shared resident rooms by use of privacy curtain. Completed : 9/23/2020 Newly hired staff will receive education as part of the orientation process.

The Administrator / Director of Nursing will complete quality assurance monitoring by observing five (5) times weekly for four (4) weeks, then weekly for (8) weeks and as necessary thereafter

The Maintenance Director and the Assistant Maintenance Director were educated by the administrator on 09/23/2020 about the importance of ensuring residents right to privacy is maintained.

A facility Privacy curtain Audit sheet will be used by the Maintenance Director and the Assistant Maintenance Director to ensure that all residents rooms have privacy curtains.

These rounds will be completed once a week for four (4) weeks, and then monthly for three (3) months. The findings will be discussed daily during 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 implanted, and the corrective action evaluated for its effectiveness. The Plan

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F 583	Continued From page 6 Resident #70's room and stated the maintenance director was in the process of ordering some. During an interview with the maintenance director on 8-21-20 at 12:50pm, the maintenance director reported the following information. He was in the process of ordering the tracks, and he needed to hang the privacy curtains. He expected the tracks to be in the building within a month. He believed Resident #70's room was a private room initially and the facility had made the room semi-private at some time. He was hired in May 2020 and did not know the exact date the room was converted to a semiprivate room or why the tracks for the privacy curtains were not ordered earlier. His plan was to put up the tracks for the privacy curtains as soon as they arrived in the facility. The Administrator was interviewed on 8-27-20 at 10:47am. During the interview, the Administrator was not able to validate how long the privacy curtains had been missing from Resident #70's room or what efforts the facility had taken to afford privacy prior to 8-26-20 for Resident #70.	F 583	of Correction is integrated into the quality assurance system of the facility. The Administrator will complete quality assurance monitoring by observing five (5) random resident rooms for cleanliness and need of repairs and use / need of privacy curtains. Monitoring will be completed five (5) times weekly for four (4) weeks, then weekly for eight (8) weeks and as necessary thereafter. The Administrator will report findings of the monitoring for the daily Interdisciplinary Team meeting. The results of all audits and monitoring will be submitted to the QAPI Committee monthly for three (3) months and will make changes to the plan as necessary to maintain compliance with residents□ rights to a clean, homelike environment.	
F 584 SS=B	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.	F 584		10/2/20

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F 584	Continued From page 7 (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, 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 observations, resident and staff interviews and review of facility maintenance records, the facility failed to maintain a bathroom door in good repair in 1 of 6 resident rooms (Room 115) on the 100 hall and failed to maintain a clean living environment for 2 of 21 residents (Resident #54 and Resident #90) reviewed for environment.	F 584	Based on observations, resident and staff interviews and review of facility maintenance records, the facility failed to maintain a bathroom door in good repair in 1 of 6 resident rooms (Room 115) on the 100 hall and failed to maintain a clean living environment for 2 of 21 residents (Resident#54 and Resident#90) reviewed for environment.	

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F 584 Continued From page 8

Findings included:

1. An observation of room 115 on 8/18/20 at 3:08 PM revealed a hole on the outside of the bathroom door that measured five inches in length.

On 8/21/20 at 11:25 AM an observation of the hole on the outside of the bathroom door of room 115 was completed with the Maintenance Director (MD). During an interview with the MD on 8/21/20 at 11:27 AM, he described the hole in the bathroom door to be five inches in length and stated the hole looked to have been caused by the handle to the room's door that came in contact with the bathroom door. He explained there were clipboards at each nurse's station that staff used to communicate maintenance issues. He checked the clipboards every morning for maintenance requests and completed repairs "in order of importance." He added room audits were completed weekly and he primarily looked at window blinds, beds and furniture. The MD said he was unaware of the hole in the bathroom door of room 115.

The maintenance log book was reviewed for March through August 2020. There were no work orders placed related to the hole in the bathroom door of room 115.

An interview with the Director of Nursing (DON) was held on 8/21/20 at 12:54 PM. She expressed the facility was in a state of transition and several new staff and managers had been hired to "take care of all the areas we've identified that need some extra attention."

2a. Resident #54 was admitted to the facility on

F 584

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:

Housekeeping cleaned areas identified in resident room #212 and room #305 was cleaned.

Completed: 8/21/2020

Housekeeping Director completed environmental surveillance of resident rooms and living areas to identify, and address cleaning needs to ensure residents right to a clean, homelike environment.

Completed: 9/23/2020

The Maintenance Director fixed the bathroom door in room 115

Completed: 9/23/2020

Housekeeping Director provided education to housekeeping staff on the residents right to a clean, homelike environment. A daily/weekly/monthly cleaning schedule including general and deep cleaning criteria will be maintained and monitored by the Housekeeping Director. Newly hired housekeeping staff will receive education during orientation.

The Maintenance Director and the Assistant Maintenance Director will perform room audits for areas in need of repairs will complete five (5)rooms, five (5) times weekly for four (4)weeks and then one (1) time weekly for eight (8) weeks and as necessary thereafter . A log will be kept regarding needed repairs and completed repairs .

Completed: 9/23/2020

Staff was provided education on

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F 584	Continued From page 9 7/8/20. The comprehensive Minimum Data Set assessment dated 7/13/20 indicated Resident #54 was cognitively intact. An observation of Resident #54's room on 8/18/20 at 12:02 PM revealed food particles, milk and papers on the floor near the bed by the window. An interview conducted with Resident #54 on 8/18/20 at 12:06 PM revealed it had been "a few days" since his room was cleaned by housekeeping staff. During a second observation of Resident #54's room on 8/18/20 at 3:00 PM, the food particles, milk and papers remained on the floor. During an interview with Housekeeper #1 on 8/19/20 at 9:50 AM, he stated resident rooms should be cleaned every day. He explained the rooms were to be sprayed with disinfectant, the bathrooms were to be cleaned, the floors were to be swept and mopped and trash was to be removed from the rooms. Housekeeper #1 said on 8/18/20 the housekeepers who worked on Resident # 54's hall had abruptly resigned and the rooms on the hall were not cleaned. On 8/20/20 at 2:25 PM an interview was completed with the Housekeeping Manager, during which he confirmed two of the facility housekeepers had resigned and left the building on 8/18/20 without doing their housekeeping duties. He said the rooms on Resident # 54's hall were not cleaned until later in the afternoon when he and his district manager cleaned the rooms. An interview with the Director of Nursing (DON) was held on 8/21/20 at 12: PM. She expressed the facility was in a state of transition and several	F 584	completion of the room audits and request for repairs using the maintenance clip board. Maintenance will review and schedule repairs and completed repairs. Completed: 9/23/2020 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 corrective action evaluated for its effectiveness. The PoC is integrated into the quality assurance system of the facility. The Administrator will complete quality assurance monitoring by observing five (5) random resident rooms for cleanliness and need of repairs. Monitoring will be completed five (5) times weekly for four (4) weeks, then weekly for eight (8) weeks and as necessary thereafter. The Administrator will report findings of the monitoring for the daily Interdisciplinary Team meeting. The results of all audits and monitoring will be submitted to the QAPI Committee monthly for three (3) months and will make changes to the plan as necessary to maintain compliance with residents rights to a clean, homelike environment.	

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F 584	Continued From page 10	F 584		

new staff and managers had been hired to "take care of all the areas we've identified that need some extra attention."

2b. Resident #90 was admitted to the facility on 3/11/20. The quarterly Minimum Data Set assessment dated 8/3/20 indicated Resident #90 had moderately impaired cognition.

An observation of Resident #90's room on 8/18/20 at 11:11 AM revealed several dried, brown spots on the outside of the bathroom door. Further observation of the room was completed and the privacy curtain had numerous stains at the bottom of the curtain.

A second observation of Resident #90's room was completed on 8/21/20 at 10:20 AM. There remained several dried, brown spots on the outside of the bathroom door and the privacy curtain had numerous stains at the bottom of the curtain.

Resident #90's room was observed with the Housekeeping Manager on 8/21/20 at 11:17 AM. He stated housekeeping staff were supposed to wipe down everything in the room when they cleaned, including the bathroom door. He added privacy curtains were washed upon discharge and when visibly soiled and housekeeping staff were supposed to observe and report soiled privacy curtains to they could be cleaned.

An interview with the Director of Nursing (DON) was held on 8/21/20 at 12:54 PM. She expressed the facility was in a state of transition and several new staff and managers had been hired to "take care of all the areas we've identified that need some extra attention."

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F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to accurately code a minimum data set assessment for the use of a wander / elopement alarm and for Hospice services. This was evident for 1 of 1 resident reviewed for behaviors and Hospice (Resident #14). The facility additionally failed to code a minimum data set assessment for a fall with injury. This was evident for 1 of 9 residents reviewed for accidents (Resident #69). Findings Included: 1. Resident #14 was admitted to the facility 8/22/19 and diagnoses included malignant neoplasm of the bladder, dementia, chronic pain and protein calorie malnutrition. Review of the physician ' s orders for Resident #14 revealed an order dated 8/29/19 for Hospice care and an order dated 3/13/20 to check placement and function of wander guard every shift. A care plan dated 9/14/19 for Resident #14 included information that the resident was approaching end of life and had elected hospice services. Review of an elopement assessment dated 3/12/20 for Resident #14 identified she was at risk for wandering and a wander guard was in	F 641	F641 Based on record review and staff interview the facility failed to accurately code minimum data set assessment for the use of a wander/ elopement alarm and for Hospice services. This was evident for 1 of 1 resident reviewed for behaviors and Hospice (Resident#14). The facility additionally failed to code a minimum data set assessment for a fall with injury. This was evident for 1 of 9 residents reviewed for accidents (Resident #69) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Correction of the prior assessment was completed for the resident #14 the MDS Coordinator made a correction to the following MDS Assessments to reflect accurate data for Resident #14. Corrected: 8/21/2020 Resident #14 MDS dated 5/15/2020 to accurately reflect the use of the wander guard and that the resident was receiving hospice services. Resident #69 MDS dated 6/10/2020 was completed on 9/29/2020 to accurately reflect the fall with major injury. The Director of Nursing and MDS Coordinator completed an audit of residents with orders for hospice services	10/2/20

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Continued From page 12
place.

A quarterly minimum data set (MDS) dated 5/15/20 for Resident #14 identified the resident had wandering behavior 4 to 6 days during the lookback period; was independent with transfers, bed mobility and locomotion; did not have a wander / elopement alarm and had severely impaired cognition. The MDS did not identify the resident was receiving Hospice services.

An observation of Resident #14 on 8/20/20 at 2:27 pm revealed the resident was lying in bed and a wander guard was observed to be on her left ankle.

An interview on 8/27/20 at 12:05 pm with MDS Nurse #2 revealed the MDS dated 5/15/20 for Resident #14 had been coded incorrectly. She stated the use of a wander / elopement alarm should have been coded as a "2" because the resident used the alarm daily. She additionally stated Resident #14 was receiving Hospice services during the lookback period for the MDS dated 5/15/20 and should have been coded to reflect this. Nurse #2 stated she would need to complete a modification to this MDS to correct these 2 sections.

An interview on 8/28/20 at 11:30 am with the Interim Administrator revealed she expected MDS assessments to be coded correctly.

F 641

and residents with orders for a wander guard with a review of the MDS for accuracy with focus on wander guards and hospice services. Audit for residents that had a fall with major injury and make corrections to the most recent MDS assessments if needed for inaccuracies with focus on fall with major injuries.

Completed: 9/29/2020

The Regional MDS nurse provided education to the MDS coordinator on the accuracy and completion of the MDS assessments for residents with wander guard and hospice services per RAI guidelines. The Regional MDS nurse will educate the MDS nurses on accuracy and completion of the MDS with resident fall with major injury.

Completed: 9/29/2020

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 corrective action evaluated for its effectiveness. The Plan of Correction is integrated into the quality assurance system of the facility.

The Director of Nursing and MDS Nurse will complete quality assurance monitoring for the MDS assessments for accuracy related to wander guards, hospice services and fall with major injury. Monitoring will be completed five (5) MDS weekly for four (4) weeks, then weekly for eight (8) weeks and as necessary thereafter. The Administrator will report findings of the monitoring to the IDT during QAPI meetings monthly for three (3) months and will make changes to the plans as necessary to maintain

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F 641	Continued From page 13	F 641	compliance with accuracy of assessments.	

2. Resident #69 was admitted to the facility on 1-20-20 with multiple diagnosis that included wedge compression fracture of the thoracic vertebra, chronic obstructive pulmonary disease and muscle weakness.

Resident #69's care plan dated 6-10-20 revealed a goal that the resident would not sustain serious injury. The interventions associated with the goal were in part; anticipate and meet the resident's needs, call light is within reach, ensure resident is wearing appropriate footwear and frequent toileting.

Review of Resident #69's medical record revealed the resident had an unwitnessed fall on 6-24-20 where she sustained a broken right wrist. The medical record also contained documentation the resident required a cast to her right wrist due to the wrist fracture she sustained from the fall.

The significant change Minimum Data Set (MDS) dated 7-14-20 revealed Resident #69 was moderately cognitively impaired and was coded as having falls with no injury.

MDS Nurse #1 and #2 were interviewed on 8-20-20 at 1:48pm. This interview revealed the reason the MDS had been inaccurately coded

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F 641	Continued From page 14 was because the MDS nurses had not assessed the injury as something that should be coded. MDS Nurse #1 stated, "her (the resident's) oxygen tubing pulled her backwards and that is not considered a fall with a major injury.". Nurse #2 was interviewed on 8-25-20 at 11:50am by telephone. The nurse discussed being familiar with Resident #69 and confirmed the resident had sustained a wrist fracture from an unwitnessed fall on 6-24-20. The Administrator was interviewed on 8-27-20 at 10:47am. The Administrator said she was not aware of the coding issue on Resident #69's MDS.	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services.	F 655		10/2/20

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F 655	Continued From page 15 (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop a base line care plan for a resident at risk for falls for 1 of 2 residents reviewed for falls (Resident #346). Findings included: Resident #346 was admitted to the facility on 8-12-20 with multiple diagnosis that included vascular dementia and abnormal involuntary movements. The initial nursing assessment dated 8-12-20 for Resident #346 revealed she was alert and	F 655	Based on record review and staff interviews, the facility failed to develop a base line care plan for a resident at risk for fall for 1 of 2 residents reviewed for fall (Resident#346). Resident #346 electronic medical record there was no base line care plan in the resident□s medical record. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: A comprehensive care plan review was completed for Resident #346 in default of	

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F 655	Continued From page 16 cognitively intact. The assessment also revealed Resident #346 was at risk for falls and was her own representative. Resident #346's electronic medical record revealed there was no base line care plan in the resident's medical record. The Director of Nursing (DON) was interviewed on 8-20-20 at 10:30am. The DON said there was not a base line care plan developed for Resident #346 and stated, "it just got missed." During an interview with MDS nurse #2 on 8-27-20 at 10:09am by telephone, the MDS nurse reported her time was being split between MDS duties and nursing responsibilities but more towards the nursing responsibilities. She confirmed base line care plans were completed by nursing staff and it was the unit supervisor's responsibility to ensure the base line care plan was completed. The Administrator was interviewed on 8-27-20 at 10:47am by telephone. The Administrator stated she was informed the baseline care plan was not completed for Resident #346 and said, "It should have been corrected before now, but it has been corrected."	F 655	the baseline care plan. The baseline care plan was not completed at the time of admission for this resident with the resident and with the resident representative participated in plan of care. Completed: 9/29/2020 The Director of Nursing completed an audit of baseline care plans for residents admitted from 8/4/2020-9/24/2020 The Director of Nursing, RN Unit Manager provided education to licensed nurses on guidelines for the accurate completion of baseline care plans within 48 hours of resident admission. The admitting nurse or nurse supervisor will complete the baseline care plan in collaboration with the resident and resident representative within 48 hours of admission. A copy will be offered and documented as accepted or declined. Newly hired licensed nurses will receive education as part of the orientation process. Completed:9/29/2020 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 corrective action evaluated for its effectiveness. The PoC is integrated into the quality assurance system of the facility: The Director of Nursing or RN unit manager will complete quality assurance monitoring of newly admitted residents for the accurate completion of baseline care plans. Monitoring will be completed for all new admissions within 48 hours of admission for four (4) weeks, then weekly for eight (8) weeks and as necessary thereafter. The Administrator will report	

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F 655	Continued From page 17	F 655	findings of the monitoring to the IDT during QAPI meetings monthly for three (3) months and will make changes to the plan as necessary to maintain compliance with baseline care plans.	
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). 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 observations, record review and staff	F 657	F657	10/2/20

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interviews, the facility failed to revise the care plan to reflect a significant weight loss for 1 of 7 residents (Resident #43) reviewed for nutrition, splinting for 1 of 1 resident (Resident #43) reviewed for limited range of motion, antipsychotic medication usage for 1 of 5 residents (Resident #33) reviewed for unnecessary medications and a fall with injury for 1 of 5 residents (Resident #69) reviewed for falls.

The findings included:

1. Resident #43 was admitted to the facility on 10/29/18 with diagnoses of dementia, depression and cerebrovascular disease and cerebrovascular accident.

An annual Minimum Data Set (MDS) assessment dated 7/6/20 revealed Resident #43 was 69" in height and weighed 102 pounds. The MDS further indicated Resident #43 had a weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months.

A record review revealed a weight of 109 pounds on 2/3/20 and a weight of 95.6 pounds on 7/28/20, indicating a 12.29 % weight loss in 6 months.

A dietician noted on 7/31/20 at 4:14 PM Resident #43 experienced a 5.9% significant weight loss in 1 month and a 11.1% significant weight loss in 6 months.

Resident #43 had a current physician ' s order, dated 3/20/30, for a hand splint to be applied to the right hand daily for 6-8 hours. Review of the Medication Administration Record for August 2020 revealed the splint was signed off as applied

F 657

Based on observations, record review and staff interview, the facility failed to revise the care plan to reflect a significant weight loss for 1 of 7 residents (Resident#43) reviewed for nutrition , splinting for 1 of 1 resident (Resident #43) reviewed for limited range of motion, antipsychotic medication usage for 1 of 5 residents (Resident #33) reviewed for unnecessary medications and a fall with injury for 1 of 5 residents (Resident #69) reviewed for falls. Care plan updated to include all falls
Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:
The MDS reviewed, revised and updated the current care plan for Resident #43 in collaboration with the resident and resident representative regarding weight loss and splinting. The MDS nurse reviewed, revised and updated the current care plan for psychotropic drug use for Resident #33, Resident #69 care was reviewed and updated to include all identified falls.
Completed: 9/29/2020
The MDS coordinator completed an audit of resident care plans for accuracy and timely completion with the focus on falls, splinting and psychotropics.Care Plans will be revised and update the residents care plan will be revised and updated by the IDT in collaboration with the resident and resident representative.
Completed: 9/30/2020
The Regional MDS Nurse provided education to the IDT on care plan timing and revision per RAI guidelines. The IDT

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for 8/1/20 to 8/20/20.

Resident #43 ' s care plan, dated 7/16/20, identified the resident had a problem with weight fluctuation but had not been revised to reflect the significant weight loss, which was noted on the MDS and in the dietician ' s note. The care plan also identified the resident had impaired mobility but had not been updated to include the physician ordered splint.

An interview with the MDS Nurse on 8/21/20 at 10:35 AM revealed care plans are updated quarterly and as needed. The MDS Nurse stated during routine morning meeting she reviewed the Order Listing Report and used that to update the care plans. According to the MDS Nurse, the Order Listing Report included all new orders for all the residents. The MDS Nurse stated splinting was something that should have been added to the care plan and should have been added using the Order Listing Report. She stated the Dietician received weights and updated the nutrition care plan.

An interview with the Dietician on 8/25/20 at 11:06 AM revealed she monitored the monthly weights. She stated several people were involved in care planning. She stated Resident #43 did have a significant weight loss and the care plan should have been updated to reflect the weight loss.

2. Resident #33 was admitted to the facility on 2/16/20 with diagnoses that included, in part, dementia with behavioral disturbance and unspecified mental disorder.

F 657

will complete a comprehensive care plan within seven (7) days of a RAI or MDS, except for discharge assessments with the participation of the resident and resident representative as appropriate. The MDS coordinator will maintain a schedule of comprehensive assessments (admission/readmission, quarterly and significant change) to coordinate with the IDT to ensure timely completion and revision of the comprehensive care plan per RAI guidelines. 9/29/2020 Newly hired IDT members will receive education during orientation.
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 Director of Nursing or RN Supervisor will complete quality assurance monitoring of five (5) random residents for the timely completion of the comprehensive care plan (admission, quarterly and significant change). Monitoring will be completed five (5) times weekly for four (4) weeks, then weekly for eight (8) weeks and as necessary thereafter. The Administrator will report findings of the monitoring to the IDT during QAPI meetings monthly for three (3) months and will make changes to the plan as necessary to maintain compliance with care plan timing and revision.

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Resident #33's quarterly Minimum Data Set (MDS) assessment dated 7/2/20 indicated the resident was cognitively intact. She received anti-anxiety medication and a hypnotic medication for 7 of 7 days in the look back period of the assessment.

The care plan, updated 3/17/20, did not include an area related to psychotropic medication use.

The monthly physician orders were reviewed for August 2020. Resident #33 began Buspar (an anti-anxiety medication), 5 milligrams (mg), twice a day for anxiety on 4/30/20. She was started on Trazodone (an anti-depressant medication), 50mg, at night, on 7/29/20.

An interview was completed with Resident #33 on 8/19/20 at 11:05 AM. She reported she had issues with pain in her back and leg at times but denied any signs/symptoms of depression or anxiety.

During an interview with MDS Nurse #1 on 8/20/20 at 10:49 AM, she explained if a resident was on psychotropic medications it was included in the care plan and the facility addressed issues such as risk for falls related to the medication use, change in level of consciousness or cognition and the reason a resident received a psychotropic medication. MDS Nurse #1 verified Resident #33 received psychotropic medications, and this should be on her care plan. She added she had been in the MDS position for two months and was not sure why the care plan had not been updated to reflect the psychotropic medications.

On 8/21/20 at 12:54 PM an interview was

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completed with the Director of Nursing. She said the facility had been in a transition and had hired new staff, including the MDS role. She shared MDS Nurse #1 had been in the facility for a short time and the facility was in the process of auditing the status of the care plans to make sure everything was in place.

3. Resident #69 was admitted to the facility on 1-20-20 with multiple diagnosis that included wedge compression fracture of thoracic vertebra, muscle weakness and fracture of right wrist.

Review of incident reports for Resident #69 revealed the resident had experienced falls on the following dates; 5-19-20 with no injury, 5-31-20 with discoloration to right forearm, 6-24-20 with fracture to right wrist and 8-2-20 with no injury.

The latest fall assessment dated 6-24-20 revealed Resident #69 was a high risk for falls.

The significant change Minimum Data Set (MDS) dated 7-14-20 revealed Resident #69 was moderately cognitively impaired and was coded as experiencing falls since last assessment.

Resident #69's care plan last reviewed with a date of 8-19-20 revealed a focus problem of being unsteady with transitions and a recent fall with fracture on 2-9-20. The goal for Resident #69 for the stated focused problem was "the resident will improve ADL's (activities of daily living) through the next review." The resident's care plan did not note the resident had experienced any falls after 2-9-20.

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F 657	Continued From page 22 During an interview with MDS nurse #2 on 8-20-20 at 1:48pm, the MDS nurse stated Resident #69's care plan was reviewed by staff on 8-19-20. She further stated the care plan's focus section for falls, the goals and interventions were not updated because the falls the resident experienced since 2-20-20 "did not show up on the list as falls so I missed updating that section." The Administrator was interviewed on 8-27-20 at 10:47am. The Administrator stated she had not been made aware that Resident #69's care plan had not been reviewed and updated correctly but would make sure the issue was resolved.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident interview and staff interviews, the facility failed to cut and file long jagged fingernails and ensure resident fingernails were clean and free from debris for 1 of 3 residents (Resident #346) observed for activities of daily living (ADL). Findings included: Resident #346 was admitted to the facility on 8-12-20 with multiple diagnosis that included vascular dementia and abnormal involuntary movements.	F 677	F677 Based on record review, observations, resident interview and staff interviews, the facility failed to cut and file long jagged fingernails and ensure resident fingernails were clean and free from debris for 1 of 3 residents (Resident#346) observed for activities of daily living (ADL). Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #346 received nailcare at bedside	10/2/20

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F 677

Continued From page 23

The initial nursing assessment dated 8-12-20 for Resident #346 revealed the resident needed support and physical assistance by one person for personal hygiene.

An attempt was made to interview Resident #346 on 8-18-20 at 3:11pm. The resident was unable to speak clearly making it difficult to ascertain if the resident understood the questions. The resident's fingernails on both hands were noted to be long with jagged edges and a brown substance caked underneath.

Observation of Resident #346's ADL care occurred on 8-20-20 at 10:20am with nursing assistant (NA) #5. The resident's fingernails on both hands continued to be long with jagged edges and a brown substance caked underneath the nails. NA #5 was observed trying to clean the underneath of resident #346's fingernails with a washcloth but the brown substance remained.

NA #5 was interviewed on 8-20-20 at 10:25am. According to NA #5, she was not familiar with the resident because she did not routinely work with her. NA #5 confirmed she was unable to remove the brown substance from underneath the resident's nails. She said, "I will have to ask the nurse if they have something, I can use to clean them."

An interview with Nurse #6 occurred on 8-20-20 at 11:28am. Nurse #6, who was assigned to care for Resident #346 said the NA's did not have time to cut, file and clean resident's fingernails and it was the responsibility of the activities department to care for the resident's fingernails.

During an interview with NA #4 on 8-20-20 at

F 677

Completed; 8/20/2020

The director of Nursing and Nurse Managers completed 100% of residents nails care. Residents will continue to receive assistance with nail care per resident needs and preference with daily ADL care.

Completed: 8/20/2020

The staff development coordinator and the Director of Nursing provided education to licensed nurses and nurse aides on providing and documenting nail care per the residents care plan/task list schedule. The licensed nurse will assess residents nail care needs and preferences upon admission and with changes in condition and update the care plan/task list schedule as appropriate. The nurse supervisor will monitor completion of nail care per the residents plan of care and report concerns to physician. Newly hired licensed nurses and certified staff will receive education during orientation process.

Completed: 8/21/2020

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 Director of Nursing or RN Supervisor will complete quality assurance monitoring of five (5) random residents for the completion of nail care per resident preference and ADL care.

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F 677	Continued From page 24 11:30am, NA #4 stated it was the responsibility of the NA's to cut and clean resident fingernails if the resident was not diabetic. She also said residents' fingernails were not cut or cleaned because there were not fingernail clippers "always" available. NA #4 discussed the activity department would paint residents' fingernails, but it was the responsibility of the NA's to keep them clean and cut. She added she was not aware of Resident #346's fingernails being long, jagged and dirty because she said, "that resident was not assigned to me today, but I will take care of it." The Administrator was interviewed on 8-27-20 at 10:47am. The Administrator stated she had not been made aware of any residents not receiving proper hygiene care.	F 677	Monitoring will be completed five (5) times weekly for four (4) weeks, then weekly for eight (8) weeks and as necessary thereafter. The Administrator will report findings of the monitoring during QAPI meeting monthly for three (3) months and will make changes to the plan as necessary to maintain compliance with Nail Care.	
F 686 SS=G	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 observations, record review, staff interviews and physician interview, the facility	F 686	F686 Based on observations , record review ,	10/2/20

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F 686 Continued From page 25

failed to implement physician orders to (1) provide Resident #46 pressure ulcer treatments twice a day per physicians orders and (2) implement Resident #62's physician ordered pressure reducing intervention to float heels while in bed. This failure was for 2 of 4 sampled residents reviewed for pressure ulcers.

Findings included:

1.Resident #46 was admitted to the facility on 12-13-19 with multiple diagnosis that included immobility syndrome, pressure ulcer of sacral region and muscle weakness.

The quarterly Minimum Data Set (MDS) dated 7-6-20 revealed Resident #46 was cognitively intact and was coded for having a stage 4 pressure ulcer.

Resident #46's care plan dated 7-27-20 revealed a goal the resident would not develop a new open pressure ulcer and the resident's pressure ulcer would show signs of healing and remain free from infection. The interventions listed in part were; administer treatments as ordered and monitor for effectiveness, assess/record/monitor wound healing, measure length, width and depth where possible, assess and document status of the wound perimeter, wound bed and healing progress and report improvements and declines to the physician.

Resident #46's medical record revealed the resident had a wound vac from 7-17-20 until 8-7-20 where it was documented the wound vac malfunctioned on 8-7-20.

Physician order dated 8-8-20 revealed the

F 686

staff interviews and physician interview, the facility failed to implement physician orders to (1) provide Resident #46 pressure ulcer treatments twice a day per physicians' orders and (2) implement Resident#62s' physician ordered pressure reducing intervention to float heels while in bed. This failure was for 2of 4 sampled residents reviewed for pressure ulcers.
Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:
Resident#46 continues to receive pressure ulcer treatments as ordered by the physician and complete the required documentation on the treatment record. The wound physician or Nurse Practitioner will continue to manage resident care and monitor weekly and as needed. Resident #62 continues to receive pressure relieving device to bilateral heels. Staff continue to monitor compliance and complete the required documentation.
The Director of Nursing reviewed the current month treatment records of residents with pressure ulcers and pressure relieving devices for compliance with treatments and documentation per physician's orders. The wound physician will continue to manage care and round weekly and as needed.
Completed: 9/29/2020
The Director of Nursing provided education to licensed nurses on completing and documenting of treatments for residents with pressure ulcers on the treatment record. The

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F 686	Continued From page 26 following order; clean sacrum wound with wound cleanser, pat dry, pack with Dakin wet to dry, cover with a dry absorbent dressing twice a day-every day and evening shift. Resident #46's Treatment Administration Record (TAR) for the month of August 2020 revealed no documentation of wound care being performed to the resident's sacrum on the evening shift for the following days; 8-10-20, 8-16-20, 8-18-20, 8-21-20, 8-27-20, 8-28-20, 8-29-20, 8-31-20. Resident #46's TAR for August 2020 also revealed no documentation of wound care being completed to the resident's sacrum during the day or evening shift on 8-31-20. The facility's "weekly pressure wound observation tool" was reviewed for the months of August 2020 to 9-1-2020 and revealed the following results; 8-13-20 the sacrum wound measured 2.2cm(centimeters) long, 2.5cm wide, 2.0cm deep with 1.5cm of tunneling. 8-18-20 the sacrum wound measured 2.0cm long, 2.5cm wide, 2.0cm deep and 2.7cm of tunneling. 8-27-20 the sacrum wound measured 2.3cm long, 3.0cm wide, 3.0cm deep and 3.7cm of tunneling. 9-1-20 the sacrum wound measured 3.0cm long, 3.0cm wide, 4.0cm deep and 3.0cm of tunneling. During an interview with Resident #46 on 9-1-20 at 3:05pm, Resident #46 discussed having a wound on his buttocks that was supposed to be changed twice a day. The resident stated staff was completing his wound care once a day in the mornings, but he was not receiving his wound care in the evenings. Resident #46 said he had	F 686	wound nurse will monitor treatment records for completion and report to director of Nursing as necessary. Newly hired licensed and certified staff will receive education during orientation process. Completed: 9/29/2020 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 Director of Nursing will complete quality assurance monitoring of five (5) random residents with pressure ulcers for completion and documentation as ordered. Monitoring will be completed five (5) times weekly for four (4) weeks, then weekly for eight (8) weeks and as necessary thereafter. The Administrator will report findings of the monitoring to the IDT during QAPI meetings monthly for three (3) months and will make changes to the plan as necessary to maintain compliance with pressure ulcer treatment and prevention. F688 Based on observations, record review and staff interviews, the facility failed apply a physician ordered resting hand splint for 1 of 1 resident (Resident#43) reviewed for limited range of motion. Address how corrective action will be accomplished for those residents found to	

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F 686 Continued From page 27
not been refusing for the wound care to be completed.

Observation of Resident #46's wound care occurred on 9-2-20 at 10:01am with the facility's wound care aid and nursing assistant (NA) #2. The wound care aid was noted to maintain a clean field and provide the wound care per the physician orders. The wound care aid was noted to pack the residents wound with 4x4 gauze squares wet with Dakin solution using her fingers to insert the 4x4 squares into the wounds tunneling area. The residents wound was observed to be clean with no odor or signs of infection. A very small amount of red drainage was noted.

The wound care aid was interviewed on 9-2-20 at 10:15am. The wound care aid stated she was not aware Resident #46's wound care was not being completed twice a day and said, "I work during the day, so I know it is getting done then." She also commented that the wound care nurse communicates with the physician if there are any issues with the wound.

Nurse #3 was interviewed on 9-4-20 at 3:42pm by telephone. Nurse #3 confirmed she was the wound care nurse for Resident #46 and discussed that she worked during the day. The nurse said she reported to the evening shift, the residents' that had wound care to be completed during their shift. She also stated she had realized Resident #46's wound care was not being completed in the evenings (indicated by the resident's TAR) as ordered but was not aware of the frequency. Nurse #3 stated she had reported the incomplete wound care on the evening shift to the Director of Nursing (DON) when she saw the

F 686
have been affected by the deficient practice:
Resient#43 continues to receive daily splinting to his right hand as ordered and documented per physician.
The Director of Nursing conducted an audit for the residents identified to have orders for splinting. The resident's identified have splinting devices in place and documentation was completed as required. Residents devices were checked for proper fit and wear time with referral to therapy if needed.
Completed 9/30/2020
The Director of Nursing and Nurse Manager provided education to the nursing staff on the importance of splinting and the prevention of decrease range of motion. Documentation was reviewed for compliance. Education will be provided to nursing staff with orientation process.
Completed 9/30/2020
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 Director of Nursing will complete quality assurance monitoring of five (5) residents with splinting devices five (5) times weekly for four (4) weeks and then weekly for eight (8) weeks and as necessary thereafter. The administrator will report findings of the monitoring to the

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F 686	Continued From page 28 wound care had not been completed on 8-10-20, 8-16-20 and 8-18-20 and any concerns about Resident #46's wound to the physician. The nurse commented Resident #46 was having the wound vac placed on his sacral wound today (9-4-20). An attempt was made to contact the evening shift nurses; however, it was reported by the DON the facility used different agencies and she was not aware which agency the evening nurses came from so she would not be able to provide any phone numbers. The DON also commented, since the survey, she has started handling the scheduling herself so she can have a "better understanding" on who was working and if staff was from an agency which agency. The facility's physician was interviewed on 9-4-20 at 12:25pm by telephone. The physician stated the wound care nurse changes the resident's dressing during the day and the floor staff was supposed to change it in the evenings. He said he was not aware the wound care was not being completed on the evening shift. The physician commented he was aware the resident's wound was healing with the wound vac but was not aware the wound had deteriorated. He stated he expected staff to follow the physician orders. The physician discussed the wound having the ability to become worse if the wound was not treated as ordered by staff. An interview occurred with the Director of Nursing (DON) on 9-4-20 at 1:40pm by telephone. The DON stated she was not aware of Resident #46's wound care not being completed as ordered but that she would discuss the issue with staff to find out why the wound care was not being completed. She also stated if the wound care	F 686	IDT during QAPI meetings for three (3) months and will make changes to the plan as necessary to maintain compliance with prevention of decline in range motion.	

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F 686	Continued From page 29	F 686		

could not be completed as scheduled, the nurses were responsible for documenting the reason in the nursing notes.

2. Resident #62 was admitted to the facility on 2/12/15 with diagnoses of vascular dementia and atherosclerotic heart disease.

A quarterly Minimum Data Set (MDS) assessment dated 7/17/20 revealed Resident #62 had severely impaired cognition and was totally dependent on staff for activities of daily living. Resident #62 was at risk for pressure ulcers and had current pressure ulcers. Resident #62 utilized a pressure reducing device to her bed and received pressure ulcer care.

A progress note dated 8/18/20 by the wound care physician revealed Resident #62 was seen for a stage 2 pressure ulcer to her sacrum. The wound measured 1 x 1 x 0.1 centimeters.

The resident ' s August 2020 physician ' s orders revealed a current order that was originally dated 3/12/19 to float heels while in bed for prevention.

The Medication Administration Record (MAR) for August 2020 revealed floating Resident #62 ' s heels was documented as done for the 7:00 AM to 3:00 PM shift on 8/19/20 by Nurse #4.

An observation on 8/19/20 at 3:20 PM revealed Resident #62 lying in bed. Resident #62 ' s heels were lying flat on the mattress and the heels were not floated.

An observation on 8/20/20 at 8:10 AM revealed Resident #62 lying in bed. Resident #62 ' s heels were lying flat on the mattress and the heels were

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F 686	Continued From page 30 not floated. An interview was conducted with Nurse Aide (NA) #3 on 8/20/20 at 10:00 AM. NA #3 provided care to Resident #62 on 8/20/20. She did not know why Resident #62 ' s heels were not floated on 8/20/20. NA #3 reviewed Resident #62 ' s care plan guide and did not find where Resident #62 ' s heels were to be floated. An interview was conducted with Nurse #4 on 8/21/20 at 10:10 AM. Nurse #4 provided care to Resident #62 on 8/19/20 and 8/20/20. She stated she didn ' t know why Resident #62 ' s heels were not floated and that was something the nursing assistants should do. An interview was conducted with the Director of Nursing (DON) on 8/20/20 at 12:45 PM. The DON stated she would look into why Resident #62 ' s heels were not being floated but still being signed as done.	F 686		
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 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.	F 688		10/2/20

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F 688	Continued From page 31 §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 and staff interviews, the facility failed apply a physician ordered resting hand splint for 1 of 1 resident (Resident #43) reviewed for limited range of motion. The findings included: Resident #43 was admitted to the facility on 10/29/18 with diagnoses of dementia, depression and cerebrovascular disease and cerebrovascular accident. A discharge summary by occupational therapy dated 12/6/19 indicated Resident #43 had met his short term goal to achieve normal anatomical alignment of the right hand on 11/8/19 and would be referred to a Functional Maintenance Program for splinting. A Functional Maintenance Program form dated 10/30/19 read, "Right hand - resting hand splint to be worn in AM 6-8 hours per day after he is bathed and dressed". A quarterly Minimum Data Set (MDS) assessment dated 7/17/20 revealed Resident #43 had severely impaired cognition and was totally dependent on staff for activities of daily living. Resident #43 ' s August 2020 physician ' s orders revealed an order that was originally written on	F 688	F688 Based on observations, record review and staff interviews, the facility failed apply a physician ordered resting hand splint for 1 of 1 resident (Resident#43) reviewed for limited range of motion. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resient#43 continues to receive daily splinting to his right hand as ordered and documented per physician. The Director of Nursing conducted an audit for the residents identified to have orders for splinting. The resident's identified have splinting devices in place and documentation was completed as required. Residents devices were checked for proper fit and wear time with referral to therapy if needed. Completed 9/30/2020 The Director of Nursing and Nurse Manager provided education to the nursing staff on the importance of splinting and the prevention of decrease range of motion. Documentation was reviewed for compliance. Education will be provided to nursing staff with orientation process. Completed 9/30/2020 Indicate how the facility plans to monitor	

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F 688	Continued From page 32 3/20/20 for the resident to wear a right resting hand splint daily for 6-8 hours per day. Resident #43 ' s August 2020 Medication Administration Record (MAR) revealed the resting hand splint for Resident #43 was signed off as applied on the 7:00 AM to 3:00 PM shift for 8/1/20 to 8/20/20. An observation on 8/18/20 at 10:30 AM, revealed Resident #43 lying in bed. The resident did not have a hand splint applied to his right hand. An observation on 8/18/20 at 12:10 PM, revealed Resident #43 lying in bed. The resident did not have a hand splint applied to his right hand. An observation on 8/20/20 at 10:33 AM, revealed Resident #43 lying in bed. The resident did not have a hand splint applied to his right hand. An interview was conducted on 8/20/20 at 2:56 PM, with Certified Medical Assistant (CMA) #1. She stated she was working as a nursing assistant and cared for Resident #43. CMA #1 added she was aware Resident #43 had a splint and the information may be on the care guide but they didn ' t have time to look at the care guide every day. She stated she relied on the nurses to tell her what the residents needs were if it was something the nurse wasn ' t going to do themselves. An interview was conducted with Nurse #4 on 8/21/20 at 10:10 AM. She stated it was her understanding that therapy handled the residents splinting. An interview was conducted with the Director of	F 688	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 Director of Nursing will complete quality assurance monitoring of five (5) residents with splinting devices five (5) times weekly for four (4) weeks and then weekly for eight (8) weeks and as necessary thereafter. The administrator will report findings of the monitoring to the IDT during QAPI meetings for three (3) months and will make changes to the plan as necessary to maintain compliance with prevention of decline in range motion.	

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F 688	Continued From page 33 Nursing (DON) on 8/20/20 at 12:45 PM. The DON stated she would look into why Resident #43 ' s hand splint wasn ' t being applied but being signed off on the MAR that it was. An interview was conducted with the Therapy Manager on 8/25/20 at 3:28 PM. She stated Resident #43 had a contracture to his right hand and had been on and off skilled therapy services since his admission. The right resting hand splint was ordered to keep the hand aligned. She added the splint was originally ordered to be applied at night but was not being done. She stated Resident #43 needed the splint to prevent the contracture from worsening.	F 688		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care	F 692		10/2/20

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F 692

Continued From page 34

provider orders a therapeutic diet.
This REQUIREMENT is not met as evidenced by:
Based on observations, record review and staff interview the facility failed to obtain weekly weights as recommended by the Registered Dietitian (RD) and as identified in the facility risk team meeting notes, failed to obtain weekly weights as ordered by the physican and failed to provide a nutritional supplement as orderd by the physician to address weight loss. This was evident for 3 of 9 residents reviewed for nutrition (Resident #40, Resident #43 and Resident #27).

Findings Included:

1. Resident #40 was admitted to the facility on 10/10/19 and diagnoses included traumatic brain injury, gastrostomy tube, seizures and cerebral vascular accident.

A dietary/nutrition note written by the RD dated 4/14/20 for Resident #40 stated weight was 135 lbs. 5.6% weight loss in 3 months and 15.6% weight loss in 6 months. Resident with history of weight fluctuations in facility. The goal was for the resident to gain weight. The RD recommend weekly weights for 4 weeks to monitor weight trend.

Review of a risk meeting note dated 4/16/20 for Resident #40 stated in part, the resident had significant weight loss in the last 6 months and recommendation for weekly weights for 4 weeks.

Review of a risk meeting note dated 4/29/20 for Resident #40 stated in part, to do weekly weights for 4 weeks.

F 692

F692
Based on observations , record review and staff interview the facility failed to obtain weekly weights as recommended by the Registered Dietitian(RD) and as identified in the facility risk team meeting notes, failed to obtain weekly weights as ordered by the physician and failed to provide a nutritional supplement as ordered by the physician to address weight loss. This was evident for 3 of 9 residents reviewed for nutrition (Resident#40, Resident#43 and Resident#27)
Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:
Resident#40 was re-evaluated by the IDT for the need for weekly weights effective 9/24/2020. Resident weight has remained stable over 90 days. No need for weekly weights currently. Resident#43 was re-evaluated for the continued need for weight loss. Resident#27 is no longer a resident at the facility.
Completed: 9/24/2020
The review of residents with a significant weight loss or weight gain for 5%,7.5%, and 10% weight were reviewed by the IDT. Resident within the identified weight loss or gain parameters will be replace on monitoring for weekly weights. An audit of all residents with orders for nutritional supplements related to weight loss was completed and audit of

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Review of the resident ' s weight record revealed a weight on 4/2/20 of 135 pounds (lbs.). There were no weekly weights documented for April 2020 or May 2020. The only documented weight for Resident #40 for May 2020 was on 5/5/20 of 134.5 lbs.

An interview on 8/20/20 at 10:10 am with Nurse #10 revealed she provided care for Resident #40. She stated she was not sure how often the resident was weighed, and she believed the activity staff were responsible to obtain the residents weights.

An observation of Resident #40 on 8/20/20 at 10:28 am revealed he was asleep in bed; the head of his bed was elevated. A feeding pump was infusing a name brand tube feeding formula as ordered.

An interview on 8/20/20 at 1:35 pm with the Director of Nursing (DON) revealed she was unable to locate any weekly weights for Resident #40. She explained weekly weights were initiated as part of his plan of care after the resident had a significant weigh loss in April 2020. The DON stated she had recognized there was a problem with the facility weight process.

An interview on 8/26/20 at 11:32 am with the RD revealed when she reviewed Resident #40 on 4/14/20 she recommended the facility weigh him weekly for 4 weeks because the resident had a significant weight loss. She added she did not know why the weekly weights were not done. The RD further explained she would try and verify the nutritional recommendations she had left for the facility were completed on her next visit to the facility if she had time.

F 692

supplement availability was completed.
Completed: 9/30/2020
The Director of Nursing or Nurse Manager educated the nursing staff on the importance of nutrition and hydration and monitoring for weekly weights.
Completed:9/30/2020
The Director of Nursing or Nurse Manager educated the nursing staff on the importance of nutrition and hydration and monitoring with resident weight gain or loss. The Director of Nursing educated the nursing staff to ensure the supplements identified on the meal ticket and was available on the meal tray as indicated. The Dietary Manager will educate the dietary staff to report the declining supplemental inventory and tray accuracy for resident with orders for nutritional supplements. Education will be provided with the orientation process.
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 Director of Nursing or Nursing or Administrative Nurse will complete quality assurance monitoring of five (5) residents with identified weight gain or loss weekly for four (4) weeks and weekly for eight (8) weeks and as necessary thereafter. The Administrator will report these findings to the IDT during QAPI meeting for three (3) months and will make changes to the plan

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F 692	Continued From page 36 An interview on 8/28/20 at 11:30 am with the interim Administrator revealed she expected residents would be weighed at a minimum monthly and weekly weights should be obtained if identified as part of a resident ' s plan of care. 2. Resident #43 was admitted to the facility on 10/29/18 with diagnoses of dementia, depression and cerebrovascular disease and cerebrovascular accident. An annual Minimum Data Set (MDS) assessment dated 7/6/20 indicated Resident #43 had severely impaired cognition and required extensive assistance with meals. His height was 69 inches and he weighed 102 pounds and had a weight loss of 10% or more in the last 6 months. The care plan dated 7/18/20 reflected a problem for risk for weight fluctuation with an intervention to monitor weights as ordered. Resident #43 had a current physician ' s order dated 7/19/20 to obtain weekly weights on Monday and report to physician and MDS Nurse #2. Review of Resident #43 ' s weight record revealed on 7/28/20 a weight of 95.6 pounds. Further review of the resident ' s medical record revealed no weights documented since 7/28/20. The dietician noted on 7/31/20 at 4:14 PM that Resident #43 weighed 96 pounds which reflected an 11.1 significant weight loss in 6 months.	F 692	as necessary to maintain compliance.	

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Resident #43 was observed eating breakfast on 8/20/20 at 8:50 AM. He was observed being fed by a staff member and had consumed half of his meal at that time. Resident #43 stated his breakfast was "pretty good".

On 8/20/20 at 10:29 AM MDS Nurse #2 was interviewed. She indicated she did not receive weekly weights. She confirmed Resident #43 had an order for weekly weights which were to be reported to her, but she had not received any weekly weights for Resident #43.

On 8/20/20 at 1:35 PM the Director of Nursing (DON) was interviewed. She stated she was unable to locate weekly weights for Resident #43 that were part of his plan after he had a significant weight loss in July 2020. She added she recognized there was a problem with the facility weight process.

3. Resident #27 was admitted to the facility on 3/24/15 with diagnoses that included, in part, gastroesophageal reflux disease, dysphagia and vascular dementia.

The quarterly Minimum Data Set (MDS) assessment dated 7/1/20 revealed Resident #27 had severe cognitive impairment. She required extensive assistance with eating. She was 67 inches tall and weighed 114 pounds. The MDS further indicated Resident #27 had a weight loss of 5% or more in the last month or a 10% weight loss in the last six months.

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The resident's July 2020 weights as documented in the electronic record were as follows:

7/2/20 weight= 114.8 pounds
7/9/20 weight= 116.6 pounds
7/16/20 weight= 117.2 pounds
7/23/20 weight= 120.6 pounds

A nutrition care plan updated 7/27/20 indicated a goal that the resident would have no significant weight changes and a care plan approach included, "assist with meals as needed and provide oral nutrition supplements as ordered."

The resident's August 2020 physician orders revealed an order for a nutritional supplement three times a day for weight management.

Further review of the resident's medical record on 08/19/20, revealed there was no weight documented during the month of August 2020.

On 8/19/20 from 9:15 AM to 9:37 AM, a continuous observation of Resident #27 revealed she was in her room being fed her breakfast meal by NA #1. The meal ticket on Resident #27's breakfast tray indicated she was on a puree diet with honey thickened liquids and the breakfast meal included a "frozen nutritional treat." An observation of the resident's meal tray revealed there was no frozen nutritional treat on the tray. On 8/19/20 at 9:37 AM NA #1 removed the breakfast tray from the room. Resident #27 had not received the frozen nutritional supplement nor was one offered to her during the breakfast meal.

An interview with NA #1 on 8/19/20 at 9:33 AM revealed Resident #27 needed to be fed by staff.

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She explained that if resident fed herself she ate "1-2 bites and that's all." NA #1 reported if the resident had poor intake she offered a substitute such as yogurt. She said Resident #27 received a nutritional supplement on her tray for lunch and dinner.

During an interview with the Food Service Manager on 8/20/20 at 10:15 AM, she explained the frozen nutritional supplement that was ordered for Resident #27 was placed on the resident's meal trays by the dietary staff. She added that sometimes the facility ran out of frozen nutritional supplements and on 8/19/20 the facility did not have any to serve during the breakfast meal. She added if she was out of the frozen nutritional supplements, she typically substituted a health shake, but since Resident #27 was on honey thickened liquids she didn't know what could be given as a substitute.

On 8/20/20 at 3:30 PM Nursing Assistant (NA) #1 weighed Resident #27 and reported the resident weighed 103.4 pounds which reflected the resident had experienced a 17.2 pound (or 14 percent) significant weight loss since 07/23/20.

An interview was completed with the Registered Dietician (RD) on 8/21/20 at 12:02 PM. She confirmed Resident #27 had experienced some weight loss and she recommended the resident receive a nutritional supplement with each meal. The RD added Resident #27's weights had started trending up in July 2020.

In an interview with the DON on 8/21/20 at 12:46 PM, she explained the kitchen received a copy of the recommendations for nutritional supplements and added them to a resident's meal tray. The

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F 692	Continued From page 40 DON expressed she was unaware the facility had ran out of nutritional supplements and said if she had known she would have notified a sister facility to provide the supplement until the new shipment arrived.	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interviews and physician interview the facility failed to (1) provide oxygen therapy per physician orders for 1 of 3 residents reviewed for respiratory care (Resident #69) and (2) failed to obtain an order for oxygen therapy for 1 of 3 residents reviewed for respiratory care (Resident #3). Findings included: 1.Resident #69 was admitted to the facility on 1-20-20 with multiple diagnosis that included chronic obstructive pulmonary disease and atherosclerotic heart disease. Resident #69's care plan dated 6-10-20 revealed a goal that she would not have complications related to shortness of breath and have no signs	F 695	F695 Based on observation , record review , staff interviews and physician interview the facility failed to (1) provide oxygen therapy per physician orders for 1 of 3 residents reviewed for respiratory care (Resident#69) and (2) failed to obtain an order for oxygen therapy for 1 of 3 residents reviewed for respiratory care (Resident #3) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #69 received oxygen at 3 liters via nasal cannula as ordered by the	10/2/20

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and symptoms of poor oxygen absorption. The interventions for the goal were in part; administer medication and inhalers as ordered, monitor for signs and symptoms of respiratory distress, and oxygen setting at 3 liters by nasal canula as needed.

The significant change Minimum Data Set (MDS) dated 7-14-20 revealed Resident #69 was moderately cognitively impaired and was coded for having shortness of breath and oxygen therapy.

The current physician order, which originated on 1-21-20, was for Resident #69 to receive oxygen at 3.0 liters and delivered by nasal cannula as needed.

During an observation on 8-18-20 at 12:20pm, Resident #69 was observed receiving oxygen from an oxygen concentrator, which was set at 2.0 liters rather than the prescribed 3.0 liters.

On 8-20-20 at 11:00am, Resident #69 was observed again receiving oxygen from an oxygen concentrator, which was set at 2.0 liters.

During an interview with Nurse #1 on 8-21-20 at 9:37am, Nurse #1 discussed not being familiar with Resident #69 but confirmed she was the nurse responsible for the resident on 8-21-20. She stated she checked the liters on a resident's oxygen concentrator each time she entered the residents' room. She said Resident #69 was not capable of changing the oxygen liters on the oxygen concentrator. Nurse #1 confirmed the oxygen concentrator was set at 2.0 liters and per the physician order the concentrator should be set at 3.0 liters. She stated she would contact the

physician. Resident #3 an order was placed for oxygen at 2 liters via cannula to maintain oxygen levels at or above 90%.

Completed: 8/21/2020

A review of the residents and orders for the resident with oxygen were reviewed for appropriate orders and the administration of oxygen.

Completed: 9/30/2020

The Director of Nursing and Nurse managers provided education to the nursing staff on residents that require oxygen therapy and order that must be in place. Education will be provided to all new hires with the process of orientation.

Completed: 9/30/2020

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 Director of Nursing or Administrative Nurse will complete quality assurance monitoring of five (5) residents with identified need for oxygen for five (5) times weekly for four (4) weeks, weekly for eight (8) weeks and as necessary thereafter. The Administrator will report these findings to the IDT during QAPI meeting for three (3) months and will make changes to the plan as necessary to maintain compliance.

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physician and obtain clarification.

The resident's physician was interviewed by telephone on 8-25-20 at 11:23am. The medical director discussed Resident #69 having severe chronic obstructive pulmonary disease and the disease process. He stated if he had written an order for Resident #69 to receive oxygen therapy at 3.0 liters then that was what he expected the resident to receive.

Nurse #2 was interviewed by telephone on 8-25-20 at 11:50am. Nurse #2 confirmed she routinely cared for Resident #69 and said she would check Resident #69's oxygen concentrator each time she entered the resident room to provide medication. She stated she had noticed the oxygen concentrator was on 2.0 liters but believed the physician order was for 2.0 liters and said she was unaware the resident should have been on 3.0 liters.
Resident # 3 was admitted to the facility on 8/8/20 with a history of chronic respiratory failure with hypoxia, hypertension, and coronary artery disease.
Resident #3's Significant change Minimum Data Set (MDS) assessment dated 7/31/20 revealed resident #3 was cognitively intact and required total assistance with 1-person assistance with activities of daily living.

Review of Resident #3's current plan of care, dated 4/26/20 and last reviewed 8/14/20 revealed no oxygen use.

During an observation on 08/19/20 at 10:30 AM Resident #3 was observed with oxygen tubing in nares.

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F 695	Continued From page 43 During an observation on 08/20/20 at 09:55 AM Resident #3 was observed with oxygen via nasal cannula administered at 1.5 L/min. Review of August 2020 Physician orders revealed no order for oxygen therapy. A review of Resident # 3's August 2020 nursing progress notes revealed multiple entries noting the resident was receiving oxygen. On 08/21/20 at 10:20 AM an interview was conducted with Nurse #2, who was assigned to care for Resident #5. Nurse #2 stated resident had a trach at one time and was on oxygen. She stated resident had oxygen since returning from the hospital. She stated there should be an order.	F 695		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff interview and dialysis center staff interview the facility failed to follow-up and / or implement nutritional recommendations provided by the dialysis center. This was evident for 1 of 1 resident reviewed for dialysis (Resident #84). Findings Included:	F 698	F698 Based on observations, record review, staff interview and dialysis center staff interview the facility, the facility failed to follow-up and/or implement nutritional recommendations provided by the dialysis center. This was evident for 1 of 1, resident reviewed for dialysis (Resident #84).	10/2/20

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 44 Resident #84 was admitted to the facility on 7/31/20 and diagnoses included end stage renal disease, dysphagia, acute respiratory failure and dementia. An admission minimum data set (MDS) dated 8/5/20 for Resident #84 identified the resident received dialysis, was on a therapeutic diet, required supervision with one-person assist with eating and her cognition was moderately impaired. A care plan dated 8/10/20 for Resident #84 stated the resident needed hemodialysis related to renal failure. Interventions included to encourage resident to attend dialysis scheduled for Mondays, Wednesdays and Fridays, monitor labs and report to doctor as needed and monitor, document and report any signs / symptoms of infection to access site. A care plan dated 8/10/20 for Resident #84 stated the resident had potential for nutritional problems related to renal diet. Interventions included to obtain, and monitor lab / diagnostic work as ordered, report results to physician and follow-up as needed. To provide diet as ordered and for the Registered Dietitian (RD) to evaluate and make diet change recommendations as needed. Review the medical record for Resident #84 revealed a dialysis communication form dated 8/13/20. The communication form was from the dialysis RD and contained the following recommendations: liberal renal, LCS (low concentrated sweet) or consistent carbohydrate diet, a 1500 cc fluid restriction, double protein portions with meals and 30 milliliters (ml) of a name brand protein supplement twice a day.	F 698	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #84 diet correction was completed, and fluid restrictions were implemented. Dietary received order for prescribed diet and fluid restrictions. Care plan was updated with diet change and fluid restrictions. Completed: 9/4/2020 A completed review of resident□s diets with focus on fluid restrictions recommendations from dialysis and validation of physician's orders with dietary and nursing was completed. Completed: 9/30/2020 Education was provided by the Director of Nursing and Nurse Managers to the nursing staff for residents that require and attend dialysis and recommended fluid restrictions are reported to the physician and orders are placed in residents records. Education will be provided to nursing staff as part of the new hire process. Completed: 9/30/2020 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 Director of Nursing or Administration Nurses will complete quality assurance monitoring of five (5) residents with	

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F 698	Continued From page 45	F 698	identified need for fluid restricts and prescribed diet for four (4) weeks, weekly for eight (8) weeks and as necessary thereafter. The Administrator will report these findings to the IDT during QAPI meeting for 3 months and will make changes to the plan as necessary to maintain compliance.	

Review of the physician ' s orders for Resident #84 revealed an order for a renal diet dated 7/31/20 and an order for a liquid protein supplement 30 ml twice daily dated 8/13/20. There was no physicians order for an LCS or consistent carbohydrate diet, 1500 cc fluid restriction or double protein portions with meals.

An observation of Resident #84 on 8/20/20 at 12:40 pm revealed she was eating her lunch meal. The meal tray card present on her meal tray identified her diet as a renal diet. The resident had received 2 - 8-ounce glasses of fluid and a regular portion of meat. The resident was alert, aware she went to dialysis, but was not able to discuss any details about her diet or if she was on a fluid restriction.

An interview on 8/20/20 at 12:45 pm with Nursing Assistant (NA) #4 revealed Resident #84 did go to dialysis. NA #4 was unsure if the resident was on any diet or fluid restrictions.

A nutrition note dated 8/25/20 written by the facility consultant RD for Resident #84 stated the resident received a renal diet and 30 ml of liquid protein twice daily for supplement and adequate protein. The RD recommended the resident receive large protein portions with every meal for adequate intake.

A phone interview was conducted on 8/26/20 at 11:10 am with the dialysis center ' s RD. She stated she was familiar with Resident #84 and accessed her records. The dialysis RD explained she had faxed the facility recommendations for Resident #84 on 8/13/20 that included a liberal renal, LCS or consistent carbohydrate diet, a

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F 698	Continued From page 46	F 698		

1500 cc fluid restriction, a liquid protein supplement twice daily and double protein portions with her meals. She stated if she had recommendations for a resident, she would either call or fax the recommendations to the facility. She added she also sent the monthly lab work completed at dialysis to the facility. The dialysis RD further explained the facility would send the resident ' s monthly physicians orders to the dialysis center and that she would review those to see if her recommendations had been completed. She stated they had not received the monthly orders for Resident #84, so she wasn ' t aware the recommendations she sent on 8/13/20 had been implemented. The dialysis RD added she still recommended that Resident #84 diet be changed to a liberal renal, diabetic diet with a 1500 cc a day fluid restriction.

A phone interview on 8/26/20 at 11:32 am with the facility ' s consultant RD revealed she was responsible for the nutritional assessment and clinical documentation for residents that were high nutritional risk and for new admissions. She stated she had completed a nutritional review of Resident #84 on 8/25/20 and the resident was receiving a liberal renal diet. She stated her note indicated a renal diet, but that was really a liberal renal diet. The facility RD added she had also recommended Resident #84 receive large protein portions with her meals. She stated when she assessed the resident on 8/25/20 she was not receiving a diabetic diet and was not on a fluid restriction. The facility RD explained she would communicate with the dialysis RD when she had a concern but did not believe she had spoken to anyone at dialysis regarding Resident #84. She added she was not aware the RD from dialysis had sent the facility recommendations to add a

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F 698	Continued From page 47 fluid restriction and change her diet. A phone interview on 8/28/20 at 11:30 am with the facility interim Administrator revealed the staff member that received the faxed information from the dialysis center should have notified the facility RD of the diet recommendations from dialysis. She explained once the facility RD was notified, she should follow-up with the dialysis dietitian and physician regarding the recommendations.	F 698		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 761		10/2/20

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F 761	Continued From page 48 This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility: (1) Failed to discard expired medication stored on 1 of 3 medication carts observed (300 hall med cart), (2) Failed to store medications as specified by the manufacturer on 2 of 3 medication carts observed (200 and 300 hall med carts) and (3) Failed to date open insulin on 1 of 3 medication carts observed (300 hall med cart). Findings included: 1.Accompanied by Nurse #5, an observation of the 300-hall medication cart was conducted on 8-21-20 at 10:25am. The observation revealed a Humulin N insulin pen for Resident #50 was open with an opening date of 7-17-20. Nurse #5 was interviewed on 8-21-20 at 10:27am. Nurse #5 stated once an insulin pen was opened, the insulin was able to be used for 28-30 days. She confirmed the Humulin N insulin pen for Resident #50 was expired. The nurse further stated it was the responsibility of the nurse using the medication cart to monitor for expired medication. A pharmacist, who works for the pharmacy which supplies the facility's medications, was interviewed on 8-25-20 at 10:58am by telephone. The pharmacist stated the Humulin N insulin pen dated 7-17-20 would be expired and further explained the insulin would have expired on the 28th day of the open date of 7-17-20. 2a. Accompanied by the Medication Aid (MA) #2, an observation of the 200-hall medication cart	F 761	F761 Based on observation, record review and staff interviews the facility: (1) Failed to discard expired medication stored on 1 of 3 medication carts observed (300 hall med cart) , (2) Failed to store medications as specified by the manufacturer on 2 of 3 medication carts observed (200 and 300 hall med carts) and (3) Failed to date open insulin on 1 of 3 medication carts observed (300 hall med cart). Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: All medication carts were brought into compliance for the storage of insulin and other medications with time sensitive dates. Resident #50 medication was discarded and ordered. Resident #24 medication was discarded and ordered. Completed 8/21/2020 A review of all medication carts was completed by the Director of Nursing and the staff development coordinator and medications that were expired or required dates of when open were discarded. Completed: 8/21/2020 Education was provided by the staff development coordinator to the licensed and certified staff for medications with sensitive expiration dates and storage. Education will be provided to licensed new hires as part of the orientation process. Completed: 8/21/2020 Indicate how the facility plans to monitor its performance to make sure that	

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F 761	Continued From page 49 was conducted on 8-21-20 at 10:20am. The observation revealed Resident #24 had a bottle of unopened eye drops in the medication cart. The manufacturer's instructions were for the medication to remain in the refrigerator until opened. Resident #76 was also noted to have 3 unopened Humalog insulin pens in the medication cart. The manufacturer's instructions were for the insulin to remain refrigerated until it was opened. MA #2 was interviewed on 8-21-20 at 10:22am. MA #2 stated she was unaware the unopened insulin was in the medication cart. A pharmacist, who works for the pharmacy which supplies the facility's medications, was interviewed on 8-25-20 at 10:58am by telephone. The pharmacist stated all insulins needed to be refrigerated until they were open and if that was not done then the medication needed to be returned to the pharmacy. 2b. Accompanied by Nurse #5, an observation of the 300-hall medication cart was conducted on 8-21-20 at 10:25am. The observation revealed Resident #50 had an unopened Humulin N insulin pen in the medication cart. The manufacturer's instructions were for the insulin pen to be refrigerated until open. Resident #85 was observed to have an unopened Toujeo insulin pen in the medication cart. The manufacturer's instructions were for the insulin pen to be refrigerated until opened. Nurse #5 was interviewed on 8-21-20 at 10:27am. Nurse #5 stated when she checked the medication cart for expired medications she did not check the insulins and that it was the	F 761	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 Director of Nursing or Nurse manager will complete quality assurance monitoring of a medication cart five (5) times weekly for four (4) weeks, and one (1) time weekly for eight (8) weeks and as necessary thereafter. The Administrator will report these findings to the IDT during QAPI meeting for 3 months and will make changes to the plan as necessary to maintain compliance.	

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F 761	Continued From page 50 responsibility of the nurse who had the medication cart to check for expired medication and properly stored medications. A pharmacist, who works for the pharmacy which supplies the facility's medications, was interviewed on 8-25-20 at 10:58am by telephone. The pharmacist stated all insulins needed to be refrigerated until they were open and if that was not done then the medication needed to be returned to the pharmacy. 3. Accompanied by Nurse #5, an observation of the 300-hall medication cart was conducted on 8-21-20 at 10:25am. The observation revealed 4 insulin pens and one multivial insulin bottle open and being used with no open date present. Nurse #5 was interviewed on 8-21-20 at 10:27am. Nurse #5 stated when a nurse or MA opens an insulin pen or multivial insulin bottle they are supposed to write the date they opened the medication so they know when the medication will expire. She stated she did not know why this was not done. On 8-27-20 at 10:45am, an attempt was made to discuss medication storage with the Director of Nursing, but she was not available for interview. The Administrator was interviewed on 8-27-20 at 10:47am. The Administrator stated she was not aware of the issue with medication storage.	F 761		
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 -	F 812		10/2/20

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F 812	Continued From page 51 §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 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 observations and staff interview the facility failed to ensure stored dishware was clean and dry, expired food was discarded, containers with food stored in them were clean and ensure food storage shelves were free from food spills and dust. This was evident in 1 of 1 kitchen observation. Findings Included: 1. Observation on 8/18/20 at 10:55 am revealed the kitchen ' s walk-in cooler contained 12 - 3-pound packages of cream cheese that had expired on 7/19/20. There was a 5-gallon plastic container of frosting and the top of the container ' s lid was covered in a blackish / green colored substance growing on the lid. The cooler ' s shelving units had a build-up of dried food spills and dust.	F 812	F812 Based on Observations and staff interview the facility failed to ensure stored dishware was clean and dry, expired food was discarded, containers with food storage shelves were free from food spills and dust. This was evident in 1 of 1 kitchen observation. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Removal of the items identified in the walk in cooler as expired or items not dated was completed . The items were properly discarded. Dried food spills on shelving units was were rewashed and dried properly before storage. The plastic resident serving bowls were rewashed and dried properly before storage. Completed:8/18/2020	

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F 812

Continued From page 52

An interview with the Regional Dietary Manager on 8/18/20 at 11:15 am revealed all foods should be used or discarded by their expiration date and the container of frosting needed to be thrown away. She explained the dietary staff were responsible for keeping the walk-in cooler clean and the shelving units needed to be cleaned. She added the walk-in cooler should be checked daily for cleanliness and out of date food.

2. Observation on 08/18/20 at 11:20 am revealed a cart located near the tray line contained meal trays that were stored and ready for use for lunch meal service. Observations of 20 of 20 trays stored in this cart revealed they were stacked together wet.

An interview with the Regional Dietary Manager on 8/18/20 at 11:25 am revealed all meal trays should be allowed to air dry before being placed on the cart for meal service. She added the facility had purchased an additional rack to allow for air drying, but the staff had not utilized the drying rack properly.

3. Observations on 08/18/20 at 11:30 am revealed there was a rack of 5-ounce plastic bowls stored on a clean shelf in the food preparation area. Observation of 5 of 5 of these plastic bowls revealed they contained food particles.

An interview with the Regional Dietary Manager on 8/18/20 at 11:35 am revealed all the bowls needed to be re-washed. She stated the dietary staff should make sure the bowls were clean before being placed in the food preparation area for service.

F 812

All dishes that were in the kitchen were reviewed for food participles and improper drying and storage. The walk in cooler and freezer were inspected by the regional district manager for dust , expired and non- labeled items. Dishes were in proper storage and no particles/debris were identified. Debris and dust on shelving was cleaned and corrected. All items that required labeling was corrected. An in service on expired food that includes review of expiration times, dating of opened items and allowing dishes to air dry before nesting.
Completed:8/18/2020
Dietary Manager completed education to the dietary staff on proper cleaning and storage of food including adding dates to items that are stored in walk-in cooler and expiration dates per manufactures guidelines and cleaning of the shelving in coolers. education was provided on cleaning and maintain of the walk- in cooler with the daily kitchen rounds which will include checking expired food, proper procedure and drying of dishes including storage.
Completed:8/21/2020
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.
Dietary Manager will complete quality assurance monitoring of cooler,

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F 812	Continued From page 53 An interview on 8/28/20 at 11:30 am with the interim Administrator revealed the kitchen needed a deep cleaning. She stated it was her expectation that expired foods were discarded, the walk-in cooler was clean, and dishes were clean and dry when stored for use.	F 812	refrigerator and dish area for wet dishware five (5) times weekly for four (4) weeks and one (1) time weekly for eight (8) weeks and as necessary thereafter. The Administrator will report these findings to the IDT during QAPI meeting for 3 months and will make changes to the plan as necessary to maintain Compliance.	
F 814 SS=C	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility failed to keep the dumpster area free from debris and keep the doors closed for 2 of 2 dumpsters. Findings Included: An observation on 8/18/20 at 10:00 am of the facility ' s two dumpsters revealed the doors to both dumpsters were opened. One dumpster had an open bag of trash hanging from the opened door. There were gloves, paper, trash and other debris present on the ground surrounding both dumpsters. An interview on 8/18/20 at 11:15 am with the Regional Dietary Manager revealed she believed the dietary department was responsible for keeping the dumpster area clean and the dumpster doors should be closed. She added she knew the area was cleaned by dietary staff on the previous Thursday (8/13/20).	F 814	F814 Based on observations and staff interview the facility failed to keep the dumpster area free from debris and keep the doors closed for 2 of 2 dumpsters. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The area surrounding dumpsters as identified were cleaned of debris, doors was closed. All dietary staff was in serviced on keeping the dumpsters area cleaned and the dumpsters doors closed. Completed: 8/18/2020 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	10/2/20

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F 814	Continued From page 54 Additional observations were made on 8/18/20 at 3:30 pm, on 8/19/20 at 8:30 am and on 8/19/20 at 4:00 pm. At each observation the doors to both dumpsters were open. One dumpster had an open bag of trash hanging from an opened door. There were gloves, paper, trash and other debris present on the ground surrounding the two dumpsters. An interview on 8/20/20 at 12:20 pm with the Regional Dietary Manager revealed she was not aware the dumpster area had not been cleaned up or the doors to both dumpsters remained open. She stated she had discussed this with the Housekeeping Manager, and they would develop a schedule for cleaning and monitoring the dumpster areas. An interview on 8/28/20 at 11:30 am with the interim Administrator revealed she expected the dumpster area to be free of trash and the doors to both dumpsters should be closed.	F 814	integrated into the quality assurance system of the facility. Dietary Manager will complete quality assurance monitoring of the dumpster and surrounding area of debris, five (5) times weekly for four (4) weeks and one (1) time weekly for eight (8) weeks and as necessary thereafter. The Administrator will report these findings to the IDT during QAPI meeting for three (3) months and will make changes to the plan as necessary to maintain Complian	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 880		10/2/20

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F 880	Continued From page 55 a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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F 880	Continued From page 56 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, physician interviews, lab facility interview and local health department interviews, record review, review of the "COVID19 Policy/Plan", "Accordius Health Update" policies/instructions and "Isolation-categories of Transmission Based Precautions", the facility failed to (1) monitor the staff screening process allowing a staff member (Nurse #7) to leave the screening area without taking her temperature or answering the screening questions and the facility failed to (2) implement their policies and procedures when 4 of 57 staff members (Medication Aide (MA) #2, maintenance assistant, Housekeeper (HK) #2 and therapy assistant #1) who were working with residents who were on enhanced contact droplet precautions, were observed not wearing PPE including; gloves and/or gown and not performing hand hygiene when they exited the residents room. These failures occurred during the COVID19 pandemic. Findings included:	F 880	F880 Based on observation, staff interviews , physician interviews, lab facility interview and local health department interviews, record review, review of the Covid19 Policy/Plan, Accordius Health Update policies/ instructions and Isolation-categories of Transmission Based Precautions the facility failed to (1) monitor the staff screening process allowing a staff member (Nurse #7) to leave the screening area without taking her temperature or answering the screening questions and the facility failed to (2) implement their policies and procedures when 5 of 57 staff members (Medication Aide (MA) #2 maintenance assistant, Housekeeper (HK)#2 and therapy assistant #1 who were on enhanced contact droplet precautions, were observed not wearing PPE including; gloves and /or gown and not performing hand hygiene when they exited the residents room. These failures occurred	

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F 880	Continued From page 57 1. Review of the facility's "COVID19 Policy/Plan" dated 5-6-20 revealed in part; temperatures of staff will be taken with no person permitted to work with a temperature greater than 99.6 degrees Fahrenheit. Upon arriving at the facility at 7:05am on 9-2-20 it was observed that there was no person present to screen (take temperature, ask COVID19 symptom questions and record results) visitors or staff entering the building. Observation of the screening area occurred on 9-2-20 from 7:15am to 7:30am. Nurse #7 was observed entering the facility and stopping at the screening table. She was observed trying to take her temperature with a forehead thermometer but was unable to receive a reading. Nurse #7 asked a staff member on unit 300 for another thermometer but after 5 minutes (7:20am) of waiting Nurse #7 stated "I'm going to go clock in and come back." The nurse was observed leaving the screening area without having her temperature taken or answering any COVID19 symptom questions. At 7:25am on 9-2-20, Nurse #7 was noted to return to the screening table with the activities assistant who assisted Nurse #7 in obtaining her temperature and answering the COVID19 symptom questions. The Director of Nursing (DON) was interviewed on 9-2-20 at 8:00am. The DON stated the receptionist came to work at 8:00am and would screen employees and visitors but from 11:00pm to 8:00am it was staff responsibility to follow the screening guidelines which included; writing the date, their name, the time, their temperature and	F 880	during the Covid19 pandemic. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 9/29/20 Employee #7 was re-educated on the facility Covid-19 sign in facility questionnaire and procedure. Employee #(Maintenance assistance was re-educated on resident enhanced precaution signage and the use of the required PPE before entering the posted room and the removal of the PPE when exiting the room. Employee #7 (Medication aide) was re-educated on the enhanced precautions signage and the required use od PPE posted before entering residents□ room and the proper removal of the PPE on exiting the room. The housekeeper #2 is no longer in the facility. An employee was hired as a covid-19 desk monitor to ensure covid-19 questionnaire was being completed upon entrance to the facility. Completed: 9/2/2020 The Director of Nursing completed audit to ensure that the correct signage for each resident that required enhanced precaution was in place. The Director of Nursing ensured that the required PPE equipment was in place and available to the staff. Completed: 9/2/2020 The Director of Nursing and Nurse Managers provided education to all staff on the Covid-19 questionnaire and process for entering the facility. Education to all staff on the required PPE as noted	

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answering the COVID19 symptom questions. She stated management audits the screening tool against the schedule every other day to ensure compliance. The DON confirmed Nurse #7 should not have left the screening area without completing the screening process and was not aware how many other staff maybe leaving the screening area without completing the process.

2. Review of the facility's "Isolation-Categories of Transmission Based Precautions" policy and procedure revealed in part for droplet precautions; in addition to the standard precautions all staff must remain masked in buildings where COVID19 cases are confirmed. Goggles or shields must be worn during all patient care and gowns are to be worn with COVID19 residents and/or residents on droplet precautions.

A. Observation of room 201 occurred on 8-21-20 at 11:20am. Room 201 was observed to have an enhanced contact droplet precaution sign posted on the door. Medication Aid (MA) #2 was noted in the room obtaining the residents blood pressure, pulse, temperature and oxygen saturation. The MA was not wearing gloves, eye protection or a gown. She was observed using hand sanitizer when she exited the room.

During an interview with MA #2 on 8-21-20 at 11:25am, the MA confirmed the resident had a productive cough and currently had an upper respiratory infection but stated she was not aware the resident was on enhanced contact droplet precautions and then stated, "I was just getting her vital signs." MA #2 stated she had received training on PPE and the use of PPE when a resident was on enhanced contact droplet

F 880

with the signage posted at the residents door with monitoring of application and removal. All new hires will be educated as part of the orientation process.

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 Director of Nursing or Nurse Manager will complete quality assurance monitoring of the resident requiring enhanced precautions five (5) times weekly for (4) weeks, then one (1) time a week for eight (8) weeks and as necessary. The Administrator will report these findings to the IDT meeting for three (3) months and will make changes as necessary to maintain compliance.

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precautions.

The Administrator was interviewed on 8-27-20 at 10:47am. The Administrator said she had been made aware of MA #2's lack of PPE in a resident room that had an enhanced droplet precaution sign posted and stated she believed the nurse had already re-educated the MA.

During an interview with Director of Nursing (DON) on 08/18/20 at 11:00 AM she stated the entire building was on enhanced droplet isolation precautions as of August 15, 2020 and staff were required to wear full personal protective equipment (PPE), which included: a face shield, a gown, gloves, and a N95 mask. The DON stated 7 residents (who were previously negative for COVID#19) were transferred to the hospital and 5 of those residents tested positive for COVID19 at the hospital. Continued interview with the DON stated staff were instructed to change the gown and gloves with each resident and the 100 Hall was the designated quarantine unit for new and/or readmitted residents for 14 days.

During the tour on 08/18/20 at 11:15 AM of the 100 hall an observation of the Maintenance Assistant (MA) who entered room 113 without full PPE and was moving a bed out of room 113. The MA worn a N95 mask , however no face shield, gloves or gown were observed.

On 08/18/20 at 11:22 AM an observation of Housekeeper #2 (HK) was observed in room 108 cleaning without full PPE. Housekeeper #2 had on a N95 mask, and gloves however no face shield or gown.

Observation of HK #2 on 08/18/20 at 11:25 AM

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F 880	Continued From page 60	F 880		

revealed he left cleaning room 108 and entered room 113, wearing the same soiled gloves used to clean room 108 and emptied the trash can. Again, HK#2 did not use full PPE.

An interview was conducted on 08/18/20 at 11:42 AM with MA and he stated he did not know he was to wear full PPE when entering residents' rooms. He stated he just worn a mask to just hurry up and get the bed moved.

During an observation on 08/18/20 at 11:58 AM, Therapy assistant #1 (TA) was working on the quarantine hall when he entered a resident room to give them a drink of water. TA #1 did not have on full PPE, he only worn gloves and a mask and no face shield or gown.

An interview was conducted on 08/18/20 at 12:00 PM with TA #1 and he stated he should have had on full PPE; however, he was just getting the resident some water and was trying to prevent cross contamination.

During a second interview with the DON on 08/18/20 at 1:03 PM stated there was no current COVID19 cases in the building and they have had no residents with positive results in the building. She reiterated staff are required to wear full PPE which included gown, gloves, eyewear, and mask. She stated gown and gloves are to be changed after each resident and they were able to keep the mask and face shields; they are also permitted to keep gown in each room on a hook for entire shift. DON stated staff were verbally educated on August 15-17, 2020 of the new precautions as well as literature of precautions on each unit to educate staff and did not know why

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F 880	Continued From page 61 the staff was not wearing full PPE on the quarantine unit, but she would take care of it.	F 880		
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview the facility failed to provide a resident with a call light or an alternative communication method to call for staff assistance. This was evident for 1 of 83 residents screened during the survey (Resident #11). Findings Included: Resident #11 was admitted to the facility 2/1/18 and diagnoses included functional quadriplegia and Alzheimer ' s Disease. A quarterly minimum data set (MDS) dated 8/18/20 for Resident #11 revealed she was totally dependent with 2-person assist for her activities of daily living and her cognition was moderately impaired. Review of Resident #11 ' s care plan dated 8/28/20 included an intervention to keep the resident ' s call bell within reach and re-orient to the call bell for staff assistance.	F 919	F919 Based on observations, record review and staff interview the facility failed to provide a resident with a call light or an alternative communication method to call for staff assistance. This was evident for 1 of 83 residents screened during the survey (Resident 11) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #11 was not identified with the resident roster as provided by the state for the survey Completed: 9/24/2020 An Audit was conducted in each of the residents' rooms for call bell device. The call bells were in place and properly functioning. There were no other rooms identified that had 2 residents and one call bell. Completed: 9/2/2020	10/2/20

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F 919

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An observation on 9/1/20 at 12:20 pm revealed Resident #11 was lying in bed. This surveyor asked the resident if she could reach her call light and Resident #11 responded "well, it ' s not here anywhere". There was no call light observed to be anywhere within reach of the resident. There was no call bell wall unit observed to be on the resident ' s side of the room. There was no alternative communication system observed for the resident to use.

An observation and interview with Nursing Assistant (NA) #8 was conducted on 9/1/20 at 12:30 pm. NA #8 was observed to look all around Resident #11 ' s bed and her section of the room for the resident ' s call light. NA #8 stated she did not see a call light anywhere. She added she did not realize the resident didn ' t have a call light and stated Resident #11 was able to use the call light if it was available to her.

An observation and interview with the Maintenance Director (MD) was conducted on 9/1/20 at 1:15 pm. The MD stated he did not see any call light on Resident 11 ' s side of the room. He stated he believed this room was originally intended to be a private room and when the facility made it a semi-private room there was no call bell access to that side of the room. The MD added he would have to try and install one for Resident #11 or they would need to move the resident to another room.

An interview on 9/1/20 at 3:30 pm with a Corporate Representative (CP) revealed she thought the resident had a hand bell in her room because there wasn ' t a call light on her side of the room. She stated she was not sure how long

F 919

The Director of Maintenance educated the managing staff on the call bell requirements per resident. Employee education performed by the maintenance director with the call bell requirements for each resident. The Maintenance Director will provide education to all new hires as part of the orientation process.
Completed: 9/2/2020
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 Maintenance Director and Assistant Maintenance Director will complete quality assurance monitoring of the resident call bell in place for five (5) times weekly for four (4) weeks thereafter. The Administrator will report the findings to the IDT meeting for three (3) months and will change to the plan as necessary to maintain compliance.

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F 919	Continued From page 63 Resident #11 had resided in that room and she would be moved to another room with a functioning call light. An interview on 9/1/20 at 4:00 pm with the interim Administrator revealed Resident #11 had been moved to another room. She added it was her expectation that all residents had a communication system to call for staff assistance.	F 919		