STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345336	A. BUILDING ______ B. WING ______	C 01/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF ROANOKE RAPIDS	**305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870**

(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 COVID-19 Focused Survey was conducted on 1/20/2021-1/27/21. The facility was found in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# 02HR11	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and complaint investigation were conducted on 1/20/2021-1/27/2021. The facility was not found in compliance with 42 CFR §483.80 infection control regulations and has not implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. 6 of the 16 complaint allegations were substantiated resulting in deficiencies.	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	F 550		2/16/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 02/11/2021

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 access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and 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 and staff interviews the facility failed to provide a dignified dining experience when staff stood over a resident while providing feeding assistance for 1 of 1 resident reviewed for dignity (Resident #3). The findings included: Resident #3 was admitted to the facility on 4/6/16 with diagnoses that included dementia. The quarterly Minimum Data Set (MDS) assessment dated 11/10/20 indicated Resident #3's cognition was moderately impaired with	F 550	F550 1. Education provided to Nurse Aide # 1 on Residents Rights as it pertains to providing a dignified dining experience by sitting eye level while providing feeding assistance. 2. All residents had the potential to be affected by this deficient practice. 3. Education on Residents Rights as it pertains to providing a dignified dining experience by sitting at eye level while	

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F 550	Continued From page 2 unclear speech. Resident #3 was assessed as having no behaviors. She required extensive assistance with bed mobility, toilet use, and eating. She was dependent for dressing, personal hygiene and bathing. Resident #3 received hospice services and oxygen therapy. An interview was attempted with Resident #3 on 1/20/21 at 12:15 PM. She was unable to be interviewed. During an observation on 1/20/21 from 1:01 PM until 1:20 PM Resident #3 was in bed being fed by Nurse Aide (NA) #1 who was standing next to the resident's bed. During the meal observation NA #1 continued to stand over Resident #3 as she fed him. During an interview with Nurse Aide #1 on 1/20/21 at 2:42 PM she reported residents who need assistance with feeding can be fed either standing or sitting. She indicated she was unaware that residents should be fed at eye level. An interview was conducted with Nurse #2 on 1/20/21 at 3:20 PM who stated residents should be fed while sitting at eye level. An interview was conducted with the Interim Director of Nursing on 1/20/21 at 3:45 PM who stated that residents should be fed while at eye level. She indicated Nurse Aide #1 should have fed Resident #3 while sitting. During an interview with the Administrator on 1/25/21 at 3:55 PM she stated residents should be fed with staff sitting at eye level. She indicated Nurse Aide #1 should have fed Resident #3 while sitting.	F 550	providing feeding assistance was provided to the Licensed Nurses and Certified Nursing Assistants by 02/15/21. This training will also be provided to all Licensed Nurses and CNAs upon hire during orientation. 4. Ongoing audits by the Director of Nursing, Assistant Director of Nursing and/or Unit Manager for observation and review to ensure staff are sitting eye level with the residents while providing feeding assistance. These audits will be conducted 5 x week for two weeks, weekly for two weeks and monthly for three months. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Administrator. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, Staff Development Coordinator, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise. 5. The Administrator and Director of Nursing is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by February 16, 2021.	

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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 observations, staff interviews and record review the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of behaviors for 2 of 11 residents whose MDS assessments were reviewed (Resident #4 and Resident #5). The findings included: 1. Resident #4 was admitted to the facility on 8/26/19 with diagnoses that included dementia. A nursing progress note dated 8/25/20 revealed Resident #4 wandered in and out of other residents' rooms, was noncompliant with social distancing and wearing a face mask. Resident #4's annual Minimum Data Set (MDS) assessment dated 9/1/20 revealed in section E, Resident #4 had no behaviors during the 7-day look back period. Section P revealed Resident #4 utilized a wander alarm daily. Section E of the assessment was completed by the Social Worker. Review of the Care Area Assessment (CAA) summary dated 9/1/20 for Resident #4 revealed no assessment was completed for behavioral symptoms. Observations conducted on-site 1/20/21 revealed Resident #4 wandering throughout the facility	F 641	F641 1.The facility failed to accurately code the MDS reviewed for Resident #4 and Resident #5 in the area of behaviors. MDS Coordinator modified and re-submitted MDS for Residents #4 and Resident #5. MDS Coordinator educated regarding expectations for accurately coding MDS upon identification of errors. 2. All residents have the potential to be affected by this alleged deficient practice. The MDS Coordinator/designees and Regional MDS Consultant will complete a review of assessments for residents Section E by February 15, 2021. Modifications will be completed as indicated by MDS Coordinator. 3. Education will be provided to MDS Coordinators by 02/12/2021 on the RAI guidelines related to accurate coding of Section E- Behaviors and Social Worker. This training will also be provided to all MDS nurses and Social Worker upon hire during orientation. 4. The RN MDS Consultant nurse will complete an audit of 3 resident□s MDS Assessments weekly x 4 weeks to ensure accurate coding; then 2 resident□s MDS	2/16/21

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F 641

Continued From page 4

accompanied by a Nurse Aide providing one to one care.

During an interview with the Social Worker on 1/22/21 at 1:12 PM she stated Resident #4's 09/01/21 MDS assessment was inaccurate regarding behaviors and should have noted the resident had exhibited wandering behaviors during the 7-day look back period.

During an interview with the Administrator on 1/26/21 at 2:27 PM she indicated Resident #4's behaviors should have been coded accurately on his assessment.

2. Resident #5 was admitted to the facility on 8/28/20 with diagnoses that included diabetes mellitus and end stage renal disease. The resident discharged from the facility on 10/28/20.

A nursing progress note dated 9/24/20 indicated Resident #5 had refused care.

A nursing progress note dated 9/25/20 indicated Resident #5 had verbal behaviors directed towards others.

A nursing progress note dated 9/28/20 indicated Resident #5 had verbal behaviors directed towards others.

Resident #5's annual Minimum Data Set (MDS) assessment dated 9/30/20 revealed in section E, Resident #5 had no behaviors during the 7-lookback period.

Review of the Care Area Assessment (CAA) summary dated 9/30/20 for Resident #5 revealed no assessment was completed for behavioral

F 641

Assessments weekly x 2 weeks: then 1 monthly resident□s MDS Assessments x 3 months. Education will be provided as indicated. All data will be summarized and presented to the facility QAPI meeting monthly x 3 months by the MDS Coordinator. Any issues or trends identified will be addressed by the QAPI Committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, Staff Development Coordinator, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise.

5. The Administrator and RN MDS Nurse is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by February 16, 2021.

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F 641	Continued From page 5 symptoms. During an interview with the Social Worker (SW) on 1/22/21 at 1:12 PM she stated Resident #5's 09/30/20 MDS assessment was inaccurate regarding behaviors and it was an error. The SW explained the resident's 09/30/20 MDS should have included the resident's behaviors that were documented during the seven day look back period. During an interview with the Administrator on 1/26/21 at 2:27 PM she indicated Resident #5's behaviors should have been coded accurately on his 09/30/20 MDS assessment.	F 641		
F 655 SS=C	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) PASARR recommendation, if applicable.	F 655		2/16/21

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F 655	Continued From page 6 §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 staff and resident responsible party interviews and record review the facility failed to provide a summary of the baseline care plan to residents or their representatives for 3 of 3 residents reviewed for baseline care plans (Resident #2, Resident #5, and Resident #9). The findings included: 1. Resident #2 was admitted to the facility on 4/13/20 with diagnoses that included dementia and failure to thrive. She was discharged from the facility on 12/19/20. The quarterly Minimum Data Set (MDS)	F 655	F655 1. Facility unable to provide a summary of the baseline care plan to the resident representatives for Resident #2, Resident #5, and Resident #9 as the residents are discharged from the facility. 2. All residents had the potential to be affected. Residents or their representatives will be provided a summary of the baseline care plan for all newly admitted residents starting the month of February 2021.	

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F 655	Continued From page 7 assessment dated 10/15/20 indicated Resident #2's cognition was severely impaired. She required extensive assistance with bed mobility, toilet use, and personal hygiene. She was dependent for dressing and bathing. Resident #2 required supervision with eating. A review of the most current care plan for Resident #2 dated 8/5/20 indicated focus areas including activities of daily living needs such as bathing, dressing, and grooming, medication risks and weight loss. Record review revealed no documentation of a written summary of the baseline care plan given to the resident or responsible party. On 1/21/21 at 2:15 PM Resident #2's responsible party indicated she did not recall receiving a written baseline summary of Resident #2's care plan. On 1/22/21 at 3:30 PM the MDS Coordinator stated the baseline care plans are initiated by the assigned nurse who is admitting the resident. She stated she was not sure who was responsible for giving the representative or responsible party a written summary of the baseline care plan. During an interview with Unit Manager #1 on 1/22/21 at 3:51 PM she stated the assigned nurse activates the care plan template based on the resident's diagnoses. She stated she was unsure who reviewed or gave a written summary of the care plan to the resident. An interview with Corporate Nursing Consultant #1 on 1/26/21 at 10:30 AM was conducted. She	F 655	3. Education on the baseline care plan policy as it pertains to providing the residents or their representative a written summary of the baseline care plan prior to completion of the comprehensive care plan will be provided to the Social Service Director, Quality of Life Director and MDS Coordinators. This education will be complete by 02/15/2021. This training will also be provided to all Social Services Directors, Quality of Life Directors, and MDS Coordinators upon hire during orientation. 4. Ongoing audits will be completed by the MDS Coordinator or Regional Clinical Reimbursement Specialist for review to ensure a written summary of the baseline care plan is provided to the residents or their representatives prior to completion of the comprehensive care plan. These audits will be conducted twice a week for four weeks, weekly for three weeks, monthly for three months, and then random audits each month for two months. These audits will also include no less than 10% of the discharges from the center. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Administrator. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, Staff Development Coordinator, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director,	

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F 655	Continued From page 8 indicated the baseline care plan is implemented within 48 hours and reviewed during the full life conference following the resident's admission. During an interview with the Admissions Coordinator on 1/26/21 at 10:33 PM she stated that new residents are discussed in the daily morning meeting. She reported that each discipline meets the resident throughout that day. The Admissions Coordinator stated she did not provide written summaries of baseline care plans to residents or responsible parties. She further stated she did not know who was responsible for providing a written summary of the baseline care plan to the resident or resident responsible party. She indicated she was unaware of any documentation in the chart regarding the baseline care plan. An interview was conducted with the Administrator on 1/26/21 at 10:35 AM who stated the interdisciplinary team is responsible for completing the baseline care plan. She indicated the social worker or Admissions coordinator was responsible for providing a written summary of the baseline care plan. She reported that she was advised by the MDS Coordinator they baseline care plan did not have to be reviewed until the care plan meeting on day 21 of the resident's stay. During an interview with the Social Worker on 1/26/21 at 11:14 AM she stated she does not review or provide a written summary of the baseline care plan to residents or resident representatives. She indicated she believed that was a nursing function and they reviewed the baseline care plans with residents.	F 655	Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise. 5. The Administrator and the MDS Coordinator is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by February 16, 2021.	

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F 655	Continued From page 9 An interview was conducted with the MDS Coordinator on 1/26/21 at 11:15 AM and she confirmed she does not provide a written summary of the baseline care plan to residents or resident representatives. During an interview with the Administrator on 1/26/21 at 2:27 PM she stated a written summary of the baseline care plan should be provided to residents or responsible parties according to federal guidelines. 2. Resident #5 was admitted to the facility on 8/28/20 with diagnoses that included diabetes mellitus and end stage renal disease. The resident discharged from the facility on 10/28/20. Resident #5's annual Minimum Data Set (MDS) assessment dated 9/30/20 revealed he was cognitively intact and required supervision with bed mobility, transfer, locomotion, and eating. He required extensive assistance with dressing, toilet use, and personal hygiene. A review of the most current care plan for Resident #5 dated 10/14/20 indicated focus areas including activities of daily living needs such as bathing, dressing, and grooming, behaviors, and nutrition. Record review revealed no documentation of a written summary of the baseline care plan given to the resident or responsible party. Resident #5 was unavailable for interview. On 1/22/21 at 3:30 PM the MDS Coordinator stated the baseline care plans are initiated by the assigned nurse who is admitting the resident.	F 655		

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F 655	Continued From page 10 She stated she was not sure who was responsible for giving the representative or responsible party a written summary of the baseline care plan. During an interview with Unit Manager #1 on 1/22/21 at 3:51 PM she stated the assigned nurse activates the care plan template based on the resident's diagnoses. She stated she was unsure who reviewed or gave a written summary of the care plan to the resident. An interview with Corporate Nursing Consultant #1 on 1/26/21 at 10:30 AM was conducted. She indicated the baseline care plan is implemented within 48 hours and reviewed during the full life conference following the resident's admission. During an interview with the Admissions Coordinator on 1/26/21 at 10:33 PM she stated that new residents are discussed in the daily morning meeting. She reported that each discipline meets the resident throughout that day. The Admissions Coordinator stated she did not provide written summaries of baseline care plans to residents or responsible parties. She further stated she did not know who was responsible for providing a written summary of the baseline care plan to the resident or resident responsible party. She indicated she was unaware of any documentation in the chart regarding the baseline care plan. An interview was conducted with the Administrator on 1/26/21 at 10:35 AM who stated the interdisciplinary team is responsible for completing the baseline care plan. She indicated the social worker or Admissions coordinator was responsible for providing a written summary of	F 655		

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F 655	Continued From page 11	F 655		

the baseline care plan. She reported that she was advised by the MDS Coordinator they baseline care plan did not have to be reviewed until the care plan meeting on day 21 of the resident's stay.

During an interview with the Social Worker on 1/26/21 at 11:14 AM she stated she does not review or provide a written summary of the baseline care plan to residents or resident representatives. She indicated she believed that was a nursing function and they reviewed the baseline care plans with residents.

An interview was conducted with the MDS Coordinator on 1/26/21 at 11:15 AM and she confirmed she does not provide a written summary of the baseline care plan to residents or resident representatives.

During an interview with the Administrator on 1/26/21 at 2:27 PM she stated a written summary of the baseline care plan should be provided to residents or responsible parties according to federal guidelines.

3. Resident #9 was admitted to the facility on 9/11/20 with diagnoses that included diabetes mellitus and hypertension. The resident passed at the facility on 12/10/20.

Resident #9's admission Minimum Data Set (MDS) assessment dated 9/18/20 revealed he was severely impaired cognition. He was assessed as dependent for dressing, eating, personal hygiene and bathing. He required extensive assistance with bed mobility and bathing.

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SIGNATURE HEALTHCARE OF ROANOKE RAPIDS	305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870

(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 655	Continued From page 12 A review of the most current care plan for Resident #9 dated 9/21/20 indicated focus areas including activities of daily living needs such as bathing, dressing, and grooming, pain, and nutrition. Record review revealed no documentation of a written summary of the baseline care plan given to the resident or responsible party. Attempts to contact Resident #9's responsible party were not successful. On 1/22/21 at 3:30 PM the MDS Coordinator stated the baseline care plans are initiated by the assigned nurse who is admitting the resident. She stated she was not sure who was responsible for giving the representative or responsible party a written summary of the baseline care plan. During an interview with Unit Manager #1 on 1/22/21 at 3:51 PM she stated the assigned nurse activates the care plan template based on the resident's diagnoses. She stated she was unsure who reviewed or gave a written summary of the care plan to the resident. An interview with Corporate Nursing Consultant #1 on 1/26/21 at 10:30 AM was conducted. She indicated the baseline care plan is implemented within 48 hours and reviewed during the full life conference following the resident's admission. During an interview with the Admissions Coordinator on 1/26/21 at 10:33 PM she stated that new residents are discussed in the daily morning meeting. She reported that each discipline meets the resident throughout that day.	F 655		

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F 655	Continued From page 13 The Admissions Coordinator stated she did not provide written summaries of baseline care plans to residents or responsible parties. She further stated she did not know who was responsible for providing a written summary of the baseline care plan to the resident or resident responsible party. She indicated she was unaware of any documentation in the chart regarding the baseline care plan. An interview was conducted with the Administrator on 1/26/21 at 10:35 AM who stated the interdisciplinary team is responsible for completing the baseline care plan. She indicated the social worker or Admissions coordinator was responsible for providing a written summary of the baseline care plan. She reported that she was advised by the MDS Coordinator they baseline care plan did not have to be reviewed until the care plan meeting on day 21 of the resident's stay. During an interview with the Social Worker on 1/26/21 at 11:14 AM she stated she does not review or provide a written summary of the baseline care plan to residents or resident representatives. She indicated she believed that was a nursing function and they reviewed the baseline care plans with residents. An interview was conducted with the MDS Coordinator on 1/26/21 at 11:15 AM and she confirmed she does not provide a written summary of the baseline care plan to residents or resident representatives. During an interview with the Administrator on 1/26/21 at 2:27 PM she stated a written summary of the baseline care plan should be provided to	F 655		

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F 655	Continued From page 14 residents or responsible parties according to federal guidelines.	F 655		
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 observation, staff interviews and record review the facility failed to review and revise the plan of care related to one-to-one monitoring (Resident #4) and invite a resident to	F 657	F657 1.Comprehensive care plan updated to reflect one to one monitoring for Resident	2/16/21

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F 657	Continued From page 15 a care plan meeting (Resident #5) for 2 of 8 residents reviewed for care plans. The findings included: 1. Resident #4 was admitted to the facility on 8/26/19 with diagnoses that included dementia. Resident #4 ' s quarterly Minimum Data Set (MDS) assessment dated 11/13/20 revealed she was significantly cognitively impaired and required extensive assistance with bed mobility, dressing, toilet use and personal hygiene. She was assessed as dependent with bathing. Resident #4 wandered daily. Review of a facility report written by Nurse #3 dated 11/20/20 revealed Resident #4 wandered into another resident ' s room and demanded the resident leave. Resident #4 was placed on 15-minute checks until the other resident was discharged. During an interview on 1/21/21 at 5:35 with Nurse #3 she stated she remembered the altercation with Resident #4 and another resident on 11/20/20. She stated Resident #4 did not touch the other resident. She stated Resident #4 was placed on 15-minute checks after the incident. Review of a nursing progress note written by Unit Manager #1 dated 11/27/20 revealed Resident #4 entered another resident ' s room and slapped him. A progress note dated 12/2/20 revealed Resident #4 received 1:1 monitoring. Review of Resident #4 ' s most recent care plan	F 657	#4. Facility unable to invite Resident #5 to care plan meeting as he is discharged. 2.All residents had the potential to be affected. Care plans will be reviewed/revised, and residents/resident representatives will be invited to participate in the care plan meetings for January 2021. 3.Education on the care plan timing and revision policy along with permitting the resident/resident representative to participate in the care plan meeting. This education will be provided to the MDS Nurses and Licensed Nurses by 02/15/2021. This training will also be provided to all MDS coordinators and Licensed Nurses upon hire during orientation. 4.Ongoing audits by the Director of Nursing, Assistant Director of Nursing and/or Unit Manager for observation and review to ensure care plans are reviewed and revised. Additional audits will be completed by the MDS Coordinator for observation and review to ensure residents/resident representative are invited to participate in the care plan meeting. These audits will be conducted on 5 residents twice a week for four weeks, 5 residents weekly for three weeks, 5 residents monthly for three months, and then 2 random audits each month for two months. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the	

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F 657	Continued From page 16 dated 11/20/20 revealed an intervention in which all disciplines were to redirect the resident when she entered another resident ' s room. There were no interventions after the incident on 11/27/20 and no mention of 1:1 monitoring. Observations on 1/20/21 revealed Resident #4 receiving 1:1 monitoring from Nurse Aide (NA) #2. An interview was conducted with NA #2 on 1/20/21 at 11:20 AM who reported she had been providing 1:1 monitoring for Resident #4 for approximately a month. NA #2 stated she works with Resident #4 from 7:00 AM until 7:00 PM daily. She stated she recalled Resident #4 slapping another resident. NA #2 stated Resident #4 was not receiving 1:1 monitoring at that time. An interview was conducted with Unit Manager (UM) #1 1/22/21 at 3:27 PM who stated she reported the incident on 11/27/20 to the Director of Nursing. She stated she was unaware of any interventions that were put in place at that time. UM #1 stated she was aware Resident #4 was placed on 1:1 monitoring currently and stated she believed it began sometime after this incident. An interview was conducted with the facility Social Worker on 1/21/21 at 5:30 PM. She stated Resident #4 had been on 1:1 monitoring for a long time. The Social Worker stated she was unsure when Resident #4 was placed on 1:1 monitoring. An interview was conducted with the MDS Coordinator on 1/22/21 at 3:30 PM who stated Resident #4 ' s care plan should have been	F 657	Administrator. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, Staff Development Coordinator, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise. 5.The Administrator and Director of Nursing is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by February 16, 2021.	

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F 657	Continued From page 17	F 657		

updated to reflect 1:1 monitoring due to behaviors.

During an interview with the Administrator on 2/26/21 at 2:27 PM she indicated residents ' care plans should be updated to reflect their status.

2. Resident #5 was admitted to the facility on 8/28/20 with diagnoses that included diabetes mellitus and end stage renal disease. The resident discharged from the facility on 10/28/20.

Resident #5 ' s annual Minimum Data Set (MDS) assessment dated 9/30/20 revealed he was cognitively intact and required supervision with bed mobility, transfer, locomotion, and eating. He required extensive assistance with dressing, toilet use, and personal hygiene.

A review of the medical record revealed a care plan was developed for Resident #5 on 9/2/20. Further review of the medical record revealed there was no care plan meeting date or notes or that Resident # 5 was involved in the development of his care plan.

Resident #5 was unavailable for interview.

On 1/22/21 at 3:30 PM the MDS Coordinator stated Resident #5 did not have a care plan meeting because he was frequently at the hospital during his stay. She indicated the care plan meeting should have been scheduled.

During an interview with the Administrator on 2/26/21 at 2:27 PM she indicated residents should be invited to their care plan meetings and be involved with their care.

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F 677	Continued From page 18	F 677		
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 observations, staff interviews and record review the facility failed to provide nail care for 1 of 3 residents reviewed for activities of daily living (Resident #3). The findings included: Resident #3 was admitted to the facility on 4/6/16 with diagnoses that included dementia. The quarterly Minimum Data Set (MDS) assessment dated 11/10/20 indicated Resident #3's cognition was moderately impaired with unclear speech. Resident #3 was assessed as having no behaviors. She required extensive assistance with bed mobility, toilet use, and eating. She was dependent for dressing, personal hygiene and bathing. Resident #3 received hospice services and oxygen therapy. Resident #3's care plan last updated 11/17/20 revealed the care plan had addressed dependency on staff for activities of daily living. Review of Resident #3's medical record revealed no refusals of nail care. An observation on 1/20/21 at 11:18 AM revealed Resident #3's fingernails on both her right and left hand were long and extended past the finger.	F 677	F677 1.Nail care was provided for Resident #3. 2.All residents had the potential to be affected. An audit of the current resident population to determine the need for nail care. Nail care was provided for all identified residents by 2/15/21. 3.Education on nail care was provided to the licensed nurses and the certified nursing assistants. This education will be complete by 02/15/2021. This training will also be provided to all licensed nurses and certified nursing assistants upon hire during orientation. 4.Ongoing audits will be completed by the Director of Nursing, Assistant Director of Nursing and/or the Unit Manager for observation and validation that nail care has been provided. These audits will be conducted twice a week for four weeks, weekly for three weeks, monthly for three months, and then random audits each month for two months. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the	2/16/21

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F 677	Continued From page 19 The thumbnail on her right hand appeared broken and jagged. An interview was attempted with Resident #3 on 1/20/21 at 12:15 PM. She was unable to be interviewed. During an interview with Nurse Aide #1 on 1/20/21 at 2:42 PM she reported she had provided care to Resident #3 earlier in the morning. She stated she believed her nails were long but had understood that nail care was done on Monday. Nurse Aide #1 indicated she was unsure if Resident #3 had nail care on Monday. She further stated that nail care is part of care, but she normally provides nail care once instructed by the nurse. Nurse Aide #1 stated she believed Resident #3's nails needed to be trimmed. An interview was conducted with the Interim Director of Nursing (Interim DON) on 1/20/21 at 2:56 PM who after examining Resident #3's nails stated they were long and sharp. She further stated Resident #3's nails needed to be cut. The interim DON stated Resident #3 has refused to have her fingernails trimmed. She indicated staff should document if Resident #3 refused nail care. During an interview with Nurse #2 on 1/20/21 at 3:15 PM she stated Resident #3's fingernails were long and needed to be trimmed. She reported that she had not instructed Nurse Aide #1 to provide nail care. Nurse #2 stated she had attempted nail care in the past and Resident #3 refused. She indicated she did not document any care refusals. During an interview with the Administrator on	F 677	Administrator. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, Staff Development Coordinator, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise. 5.The Administrator and Director of Nursing are responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by February 16, 2021.	

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F 677	Continued From page 20 1/26/21 at 2:27 PM she indicated nail care should have been done and any refusals of care should have been documented.	F 677		
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. §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, staff interviews, and record review the facility failed to provide a palm protector as ordered for 1 of 1 resident reviewed for contractures. (Resident #3). The findings included: Resident #3 was admitted to the facility on 4/6/16 with diagnoses that included dementia. The quarterly Minimum Data Set (MDS) assessment dated 11/10/20 indicated Resident	F 688	F688 1.Palm protector was provided as ordered for Resident #3. 2.All residents had the potential to be affected. An audit of the current resident population was conducted to validate physician ordered splints/devices are in place. Splints/devices ordered for newly admitted residents will be initiated upon admission.	2/16/21

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F 688	Continued From page 21 #3's cognition was moderately impaired with unclear speech. Resident #3 was assessed as having no behaviors. She required extensive assistance with bed mobility, toilet use, and eating. She was dependent for dressing, personal hygiene and bathing. Resident #3 received hospice services and oxygen therapy. A nursing progress note dated 11/11/20 bilateral palm guards were applied by hospice staff during a visit. A physician's order dated 11/11/20 revealed an order for palm protectors on bilateral hands applied each shift. Resident #3's care plan last updated 10/27/20 revealed an intervention to place a rolled-up bath cloth or therapy carrot cushioning device to resident's left hand to relieve pressure to the affected area related to her hand contraction. The care plan did not reveal an intervention for her right hand contracture. An observation on 1/20/21 at 11:18 PM revealed Resident #3 did not have palm protectors in either of her hands. There was no rolled up bath cloth or therapy carrot cushioning device present. Both hands were observed to be contracted. Resident #3 was asleep. An interview was attempted with Resident #3 on 1/20/21 at 12:15 PM. She was unable to be interviewed. During an interview with Nurse Aide #1 on 1/20/21 at 2:42 PM she reported she was aware that Resident #3 was ordered palm protectors. She stated she had not seen them in Resident #3's room. Nurse Aide #1 stated she did not	F 688	3.Education on Contracture Management was provided to the licensed nurses and the certified nursing assistants. This education will be complete by 02/15/2021. This training will also be provided to all licensed nurses and certified nursing assistants upon hire during orientation. 4.Ongoing audits will be completed by the Director of Nursing, Assistant Director of Nursing and/or the Unit Manager for observation and validation that physician ordered splints/devices are in place. These audits will be conducted twice a week for four weeks, weekly for three weeks, monthly for three months, and then random audits each month for two months. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Administrator. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, Staff Development Coordinator, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise. 5.The Administrator and Director of Nursing are responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be	

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F 688	Continued From page 22 notify the charge nurse, Nurse #2, about her inability to place the palm protectors. Nurse Aide #1 stated she had not seen the resident's palm protectors at any time. During an interview with Nurse #2 on 1/20/21 at 3:15 PM she stated she was aware that Resident #3 was ordered palm protectors. She further stated she had been unable to locate them and had attempted to use a washcloth in Resident #3's hands. She reported she had not seen the palm protectors in a few days. Nurse #2 stated that she did not notify anyone about the missing palm protectors. An interview was conducted with the Interim Director of Nursing (Interim DON) on 1/20/21 at 3:45 PM. She stated Nurse #2 should have let a staff member know that Resident #3's palm protectors were unable to be located. She further stated that if the palm protectors were provided by hospice that they needed to be notified as well.	F 688	completed by February 16, 2021.	
F 825 SS=D	Provide/Obtain Specialized Rehab Services CFR(s): 483.65(a)(1)(2) §483.65 Specialized rehabilitative services. §483.65(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- §483.65(a)(1) Provide the required services; or	F 825		2/16/21

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F 825	Continued From page 23 §483.65(a)(2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and family interview, the facility failed to provide a Speech Therapy evaluation for 1 of 1 resident (Resident #2) reviewed for speech therapy referrals. The findings included: Resident #2 was admitted to the facility on 4/13/20 with diagnoses that included dementia and failure to thrive. She was discharged from the facility on 12/19/20. The quarterly Minimum Data Set (MDS) assessment dated 10/15/20 indicated Resident #2's cognition was severely impaired. She required extensive assistance with bed mobility, toilet use, and personal hygiene. She was dependent for dressing and bathing. Resident #2 required supervision with eating. Review of Resident #2's care plan last reviewed on 8/4/20 revealed a problem of poor food intake with an intervention for speech therapy as needed. A restorative progress note written by Restorative Nurse #1 dated 10/12/20 revealed Resident #2 was participating in restorative dining. The note read in part, "Referred to speech therapy but will	F 825	F825 1.Speech therapy evaluation unable to be completed on Resident #2 as she is discharged. 2.All residents had the potential to be affected. An audit of the current resident population was conducted to validate speech therapy referrals were initiated as ordered for beginning the month of January 2021. Speech therapy referrals will be initiated for newly admitted residents as deemed necessary. 3.Education on Specialized Rehabilitative Services as it pertains to residents receiving therapy services as required per their assessment and plan of care was provided to the Licensed Nurses and Rehab staff. This education will be completed by 02/15/2021. This training will also be provided to all Licensed Nurses and Rehab Staff upon hire during orientation. 4.Ongoing audits will be completed by the Rehab Services Manager to validate that all therapy referrals are appropriately documented and carried out as per the	

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	345336	A. BUILDING ______ B. WING ______	C 01/27/2021

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continue to work towards goal of set up level of assistance with minimal assistance".

Review of a restorative progress note written by Restorative Nurse #1 dated 10/16/20 revealed Resident #2 was discharged from restorative dining services.

An interview with Restorative Nurse #1 was conducted on 1/22/21 at 1:15 PM. The nurse stated Resident #2 was discharged from restorative dining services because she made a verbal referral for a speech therapy evaluation. She reported Resident #2 was not making any progress in restorative dining and had plateaued. Restorative Nurse #1 stated she was not aware that the speech evaluation was never conducted. She stated she spoke verbally with the speech therapist about the referral. The nurse reported the speech therapist soon left the facility as an employee following their conversation about Resident #2's referral.

Review of Resident #2's record revealed no speech therapy evaluation was conducted at the time of the referral or at any time prior to Resident #2's discharge.

Progress notes dated 12/14/20-12/18/20 revealed Resident #2 had poor food intake and was pocketing food.

A doctor's progress note dated 12/18/20 indicated Resident #2's condition was deteriorating due to poor food intake and refusing medication.

A social work note dated 12/18/20 indicated the social worker had spoken to Resident #2's responsible party (RP) regarding Resident #2's

F 825

residents plan of care. These audits will be conducted twice a week for four weeks, weekly for three weeks, monthly for three months, and then random audits each month for two months. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Administrator. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, Staff Development Coordinator, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise.

5.The Administrator and Rehab Services Manager is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by February 16, 2021.

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condition and to discuss the possibility of comfort care. The note further revealed that the RP wanted to speak with other relatives prior to deciding.

During an interview with the social worker on 1/21/21 at 5:30 PM the social worker stated she spoke with the RP again on 12/19/20 and the RP requested Resident #2 be evaluated for a feeding tube. The social worker reported the RP indicated Resident #2 would want measures to prolong her life.

During an interview with Resident #2's RP on 1/21/21 at 2:15 PM she stated she was not made aware that Resident #2 was refusing to eat until she was approached by the facility social worker in December, 2020. She stated the social worker attributed the resident's poor eating to dementia and suggested comfort care. She stated she informed the social worker the resident would want interventions to sustain life. The family member stated she asked about the possibility of a feeding tube and they requested the resident be transferred to the hospital for an evaluation.

An interview was conducted on 1/22/21 at 12:51 PM with the Rehabilitation Manager who reported that a speech therapy evaluation was not done following the October, 2020 referral or at any time prior to the resident's discharge. She stated that a written referral for a speech therapy evaluation should have been completed rather than a verbal referral.

During an interview with the Administrator on 1/26/21 at 2:27 PM she indicated the speech therapy evaluation should have been done. She stated that a written referral should have been

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F 825	Continued From page 26 completed to ensure the evaluation was done. According to hospital medical records, Resident #2 received evaluation of her poor eating and swallowing ability when she was transferred to the hospital on 12/19/20.	F 825		
F 880 SS=D	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 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	F 880		2/22/21

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F 880	Continued From page 27 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. §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 observations, resident and staff interviews, the facility failed to transfer a resident's cigarettes from the quarantine hall	F 880	F880 1.Resident #1 cigarettes have been	

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nursing station when the resident was transferred off of the quarantine unit causing a nonquarantine resident to self-propel his wheelchair down the quarantine hall to request cigarettes for 1 of 6 residents (Resident #1) reviewed for infection control.

Findings included:

Resident #1 was observed on 1/20/2021 at 10:20 am to self- propel his wheelchair through the open double doors of the quarantine hall and down the quarantine hall toward the nursing station without a mask.

An interview with Resident #1 on 1/20/2021 at 10:30 am revealed the resident would sometimes go down to the nursing station through the quarantine hall to request his cigarettes before his smoke break. Resident #1 stated sometimes he would wait until the nurse aide brought his cigarettes to him.

During an interview with Nurse #1 on 1/20/2021 at 10:45 am she stated Resident #1 used to be on the quarantine unit as a new admission and was moved off the unit on December 19, 2020 because his quarantine period had been completed. Nurse #1 said Resident #1 continued to come down the quarantine hall to the nurse's station to request cigarettes because his cigarettes were not transferred to another nursing station after Resident #1 was moved off the quarantine unit.

The Administrator stated during an interview on 1/20/2021 at 10:15 am that she did not know why Resident #1's cigarettes were still at the nursing station on the quarantine unit and the cigarettes

F 880

transferred to the nonquarantine unit.

2. All residents had the potential to be affected by the deficient practices. Education will be provided to all staff on Infection Control as it pertains to transferring resident belongings to the nonquarantine area of the facility once the resident is transferred off the quarantine hall. This will be completed by 2/15/21.

3. Education on the Infection Control Policy as it pertains to transferring resident belongings to the nonquarantine area of the facility once the resident is transferred off the quarantine hall. This training will also be provided to all staff upon hire. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Administrator. Any issues or trends identified will be addressed by the QAPI committee as they arise, and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, Staff Development Coordinator, MDS Coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise.

4. The Root Cause Analysis was conducted by the Infection Preventionist, QAPI Team and Governing Board and the root cause of the cited deficient practices was determined to be a need for further

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F 880	Continued From page 29 would be moved to another nursing station.	F 880	education and observations regarding Infection Control as it pertains to transferring resident belongings to the nonquarantine area of the facility once the resident is transferred off the quarantine hall. The RCA also revealed there is a need for more frequent observations to ensure that residents that are not on quarantine are not on the quarantine hall. Due to the findings of the RCA, the above education will be completed, and then ongoing audits will be conducted by the Admissions Coordinator to ensure compliance. These audits and observations will be conducted 5 days a week for 4 weeks, 2 x weekly for four weeks, weekly for four weeks and then monthly x 3 months. Any incident of non-compliance with Infection Control guidelines as it relates to nonquarantine residents being on the quarantine hall will be addressed as they arise. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Administrator. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, Staff Development Coordinator, MDS Coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 880	Continued From page 30	F 880	5.The Administrator and Director of Nursing will be responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by 2/16/2021.	