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	345233	A. BUILDING _____ B. WING _____	C 04/12/2021

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E 000	Initial Comments An unannounced Recertification survey was conducted on 3/28/2021 through 3/31/2021. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # X4BQ11.	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 3/28/21 to conduct a recertification survey and complaint investigation survey and exited on 3/31/21. An extended survey was completed on 4/12/21. Therefore, the exit date was changed to 4/12/21. A total of 7 allegations were investigated and 2 allegations were substantiated. Event ID # X4BQ11. The facility was notified on 04/12/2021 of Substandard Quality of Care identified after management quality review: Substandard Quality of Care was identified at CFR 483.10 at tag F550 at a scope and severity (H).	F 000		
F 550 SS=H	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	F 550		5/7/21

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

Electronically Signed | 04/26/2021

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F 550	Continued From page 1 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 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 record reviews, staff interviews, and resident interviews the facility failed to maintain dignity and preference by residents not having briefs available. This affected 7 out of 7 (#58, #16, #4, #13, #17, #26, #77) sampled residents. The residents expressed feelings of being upset, it was awful, they were scared, embarrassed and uncomfortable to leave their rooms, it was unacceptable, and that the nursing home did not	F 550	1.On 3/11/2021 a facility inventory of briefs was conducted; a brief PAR level was established by central supply and will include a 3 day emergency supply of briefs. 2.On 4/6/2021 a quality review was completed for the current facility residents by the social worker to ensure that their brief preferences were being honored.	

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F 550	Continued From page 2 care about them. The findings included: 1. Resident #58 was originally admitted to the facility on 03/17/21 and re-admitted on 02/08/21. A review of the quarterly Minimum Date Set (MDS) dated 02/15/21 indicated Resident #58 was cognitively intact and was total dependent of all activities of daily living (ADL) except for eating. The MDS further revealed Resident #58 was incontinent. An interview was conducted with Resident #58 on 03/28/21 at 9:30 AM revealed that a couple of weeks ago the facility ran out of briefs and he was without briefs for three days. Resident #58 further revealed that he was upset and did not like laying on the bed pad. Resident #58 stated he complained to nursing staff for several days. An interview was conducted with Nurse Aid #2 (NA) on 03/30/21 at 10:13 AM revealed in the month of March there was a shortage of briefs for an estimated time of one week in the facility. She further revealed residents who went without a brief would have a bed pad placed underneath them. The NA revealed residents went three days without briefs and residents complained not wanting to leave their rooms scared they would have an accident in front of other residents. An interview was conducted with Nurse #12 on 03/31/21 at 9:41 AM revealed there was a shortage of briefs in the facility a couple of weeks ago. The Nurse further indicated residents ran out of briefs and would have a bed pad placed underneath them instead. The Nurse revealed Resident #58 did run out of briefs and was very	F 550	Any concerns that were identified were immediately corrected. 3.On 4/15/2021 central supply was re-educated by the Administrator on establishing a Par level for briefs and maintaining a 3 day emergency supply. On 4/21/21 the Administrator was re-educated by the VP of Clinical Operations in the importance of reviewing and approving supply orders in a timely manner. 4.Central supply/Designee will conduct a quality review weekly X 6 weeks, then monthly X 3 months to validate the PAR level and 3 day emergency supply is maintained. The facilities Director of Nursing/Designee will conduct a quality review of 10 residents off each unit if (applicable) weekly X 6 weeks, then monthly X 3 months to ensure resident's preferences are established and maintained specifically concerning briefs. Quality reviews will be forwarded to QAPI monthly until QAPI deems substantial compliance has been achieved and recommends quarterly reviews. 5. Completion date 5/7/2021	

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F 550	Continued From page 3	F 550		

upset.

An interview was conducted with the Central Supply Manager on 03/31/21 at 11:00 AM revealed a supply ordered did not get approved on 02/27/21 and caused a supply shortage of briefs. It was further revealed the facility had an abundance of pull ups that were stored in the linen closet for nursing staff to use instead of briefs. She could not recall if nursing staff was educated about the supplies' location. The Central Supply Manager revealed she did not document number of supply inventories in the facility.

An interview was conducted with the Director of Nursing (DON) on 03/31/21 at 1:17 PM revealed that the facility missed a supply order which caused a shortage of briefs. The DON further indicated that briefs were borrowed from another facility and there were disposable pulls up for residents. The DON revealed residents were asked if they would use a bed pad instead of a brief during third shift and does not recall any residents complaining.

An interview conducted with the Administrator on 03/31/21 at 6:00 pm revealed the supply order was not signed off on 02/27/21 causing the facility to be low on briefs. She further revealed that the facility received supplies from another facility and had abundance of pull ups for the residents. The Administrator revealed she does not recall any residents complaining or being upset.

2. Resident #16 was admitted to the facility on 12/04/21 and re-admitted on 07/07/18.

A review of the quarterly Minimum Date Set

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(MDS) dated 01/08/21 indicated Resident #16 was cognitively intact and was dependent requiring extensive assistance with all Activities of Daily Living (ADL) except for eating. The MDS further revealed Resident #16 was frequently incontinent.

An interview was conducted with Nurse Aid #2 (NA) on 03/30/21 at 10:13 AM revealed in the month of March there was a shortage of briefs for an estimated time of one week in the facility. She further revealed residents who went without a brief would have a bed pad placed underneath them. The NA revealed residents went three days without briefs and residents complained not wanting to leave their rooms scared they would have an accident in front of other residents.

An interview was conducted with Nurse #12 on 03/31/21 at 9:41 AM revealed there was a shortage of briefs in the facility a couple of weeks ago. The Nurse further indicated residents ran out of briefs and would have a bed pad placed underneath them instead.

An interview was conducted with Resident #16 on 03/30/21 at 10:30 AM revealed a couple of weeks ago the facility ran out of briefs and went a week without wearing a brief. Resident #16 further revealed he was upset and did not feel comfortable leaving his room without a brief. Resident #16 further indicated nursing staff took his packages of briefs from his room to give to other residents in the facility, and he had to use a bed pad.

An interview was conducted with the central supply manager on 03/31/21 at 11:00 AM revealed a supply ordered did not get approved

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F 550	Continued From page 5	F 550		

on 02/27/21 and caused a supply shortage of briefs. It was further revealed the facility had an abundance of pull ups that were stored in the linen closet for nursing staff to use instead of briefs. She cannot recall if nursing staff was educated about the supplies' location. The central supply manager revealed she did not document number of supply inventories in the facility.

An interview was conducted with the Director of Nursing (DON) on 03/31/21 at 1:17 PM revealed that the facility missed a supply order which caused a shortage of briefs. The DON further indicated that briefs were borrowed from another facility and there were disposable pulls up for residents. The DON revealed residents were asked if they would use a bed pad instead of a brief during third shift and does not recall any residents complaining.

An interview conducted with the Administrator on 03/31/21 at 6:00 pm revealed the supply order was not signed off on 02/27/21 causing the facility to be low on briefs. She further revealed that the facility received supplies from another facility and had abundance of pull ups for the residents. The Administrator revealed she does not recall any residents complaining or being upset.

3. Resident #4 was originally admitted to the facility on 11/28/14 and re-admitted on 10/06/18 with diagnosis that included heart failure, hemiplegia, and asthma.

A review of the quarterly Minimum Date Set (MDS) dated 12/31/20 indicated Resident #4 was cognitively intact and required 2 or more person assist with of all Activities of Daily Living (ADL) except for eating. The MDS further revealed

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Resident #4 was frequently incontinent.

An interview was conducted with Nurse Aid #2 (NA) on 03/30/21 at 10:13 AM revealed in the month of March there was a shortage of briefs for an estimated time of one week in the facility. She further revealed residents who went without a brief would have a bed pad placed underneath them. The NA revealed residents went three days without briefs and residents complained not wanting to leave their rooms scared they would have an accident in front of other residents.

An interview was conducted with Nurse #12 on 03/31/21 at 9:41 AM revealed there was a shortage of briefs in the facility a couple of weeks ago. The Nurse further indicated residents ran out of briefs and would have a bed pad placed underneath them instead.

An interview was conducted with Resident #4 on 03/30/21 at 10:45 AM revealed the facility was short on briefs for two weeks and she went without a brief for several days. Resident #4 stated it was awful and she was not okay laying on a bed pad. Resident #4 further revealed she would not leave her scared she would have an accident.

An interview was conducted with the central supply manager on 03/31/21 at 11:00 AM revealed a supply ordered did not get approved on 02/27/21 and caused a supply shortage of briefs. It was further revealed the facility had an abundance of pull ups that were stored in the linen closet for nursing staff to use instead of briefs. She cannot recall if nursing staff was educated about the supplies' location. The central supply manager revealed she did not document

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F 550	Continued From page 7	F 550		

number of supply inventories in the facility.

An interview was conducted with the Director of Nursing (DON) on 03/31/21 at 1:17 PM revealed that the facility missed a supply order which caused a shortage of briefs. The DON further indicated that briefs were borrowed from another facility and there were disposable pulls up for residents. The DON revealed residents were asked if they would use a bed pad instead of a brief during third shift and does not recall any residents complaining.

An interview conducted with the Administrator on 03/31/21 at 6:00 pm revealed the supply order was not signed off on 02/27/21 causing the facility to be low on briefs. She further revealed that the facility received supplies from another facility and had abundance of pull ups for the residents. The Administrator revealed she does not recall any residents complaining or being upset.

4. A Resident Council meeting was held on 03/31/21 at 10 AM included cognitively intact residents which included Resident #4, Resident #13, Resident #17, Resident #26, Resident #77, and Resident #16. These residents spoke out they were upset that the facility had a shortage of briefs two weeks ago and it was an issue through the whole facility. Resident #4, Resident #16, and Resident #77 stated they went without briefs several days and felt like the facility did not care about the residents. Resident #4 and Resident #16 further revealed they were scared and embarrassed to leave their rooms in case they had an accident.

An interview was conducted with Nurse Aid #2 (NA) on 03/30/21 at 10:13 AM revealed in the

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month of March there was a shortage of briefs for an estimated time of one week in the facility. She further revealed residents who went without a brief would have a bed pad placed underneath them. The NA revealed residents went three days without briefs and residents complained not wanting to leave their rooms scared they would have an accident in front of other residents.

An interview was conducted with Nurse #12 on 03/31/21 at 9:41 AM revealed there was a shortage of briefs in the facility a couple of weeks ago. The Nurse further indicated residents ran out of briefs and had a bed pad placed underneath them instead.

An interview was conducted with the Central Supply Manager on 03/31/21 at 11:00 AM revealed a supply ordered did not get approved on 02/27/21 and caused a supply shortage of briefs. It was further revealed the facility had an abundance of pull ups that were stored in the linen closet for nursing staff to use instead of briefs. She cannot recall if nursing staff was educated about the supplies' location. The Central Supply manager revealed she did not document number of supply inventories in the facility.

An interview was conducted with the Director of Nursing (DON) on 03/31/21 at 1:17 PM revealed that the facility missed a supply order which caused a shortage of briefs. The DON further indicated that briefs were borrowed from another facility and there were disposable pulls up for residents. The DON revealed residents were asked if they would use a bed pad instead of a brief during third shift and does not recall any residents complaining.

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F 550	Continued From page 9 An interview conducted with the Administrator on 03/31/21 at 6:00 pm revealed the supply order was not signed off on 02/27/21 causing the facility to be low on briefs. She further revealed that the facility received supplies from another facility and had abundance of pull ups for the residents. The Administrator revealed she does not recall any residents complaining or being upset.	F 550		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record reviews, resident, staff and physician interviews, the facility failed to use two-person transfer assist for Resident #70 which resulted in a fall without injury. This failure affected 1 of 6 residents reviewed for accidents. The findings included: Resident #70 was admitted into the facility on 04/02/19 with diagnosis which included seizures, cerebral palsy, and osteoporosis. Review of Resident #70's most recent annual Minimum Data Set (MDS) dated 02/26/21 revealed she was severely cognitively impaired. Resident #70 required extensive two-person	F 689	1.On 3/30/2021 resident # 70 care plan and Kardex was reviewed and updated to reflect the change in transfer status. 2.On 4/12/2021 a quality review was conducted on in-house residents with a 60 day look back to review falls, to ensure a complete and through investigation has been completed,and to include appropriate intervention and follow-up. Issues or concerns identified were corrected as they were identified. On 4/28/2021 a quality review on current in-house residents will be completed to ensure accuracy of Kardex.Issues or concerns will be addressed as they are identified.	5/7/21

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F 689	Continued From page 10 assistance with transfers, toilet use, personal hygiene, and bed mobility. Resident #70 was coded as having two or more falls since admission and no falls with injury or major injury. Review of Resident #70's care plan initiated on 03/16/20 and updated on 03/04/21 revealed a focus area related to falls. The goal was for Resident #70 to not sustain any serious injuries through the next review date. Interventions included total mechanical lift with all transfers, maintaining her call light within reach, bed in low position and non-skid footwear. On 3/28/21 at 12:00 PM an interview was conducted with Resident #70's Responsible Party (RP). He stated he was concerned with the amount of falls the resident had experienced in the facility and felt the facility could do something to reduce the resident's risk of an accident. Review of a fall incident report dated 12/09/20 revealed Resident #70 was assisted to the bathroom by NA #2. The resident became unstable when transferring from the wheelchair to the toilet and the staff member had to ease her to the floor. The immediate action taken included changing Resident #70 to a two-staff member assistance with transfers. On 3/30/32 at 10:02 AM an interview was conducted with NA #2. She stated on 12/09/20 Resident #70 was a one staff member assist with transfers. The interview revealed when she attempted to transfer the resident onto the toilet, she became weak and started to shake. NA #2 stated she slowly lowered Resident #70 onto the floor. NA #2 stated following the incident Resident #70's Nurse Aide Kardex was updated regarding	F 689	3. The interdisciplinary team was re-educated on 4/21/2021 by the VP of clinical Operation on the completion of an investigation to include but not limited to; a root analysis, verifying immediate interventions are in place i.e. neuro checks and change in transfer status, verifying/updating the Kardex and care plans. Licensed nursing staff and nursing assistants were re-educated by the Director of Nursing on 4/13/2021 and 4/15/2021 and ongoing to include but not limited to appropriate fall/transfer procedures with return demonstration. On 4/27/2021 and 4/29/2021 and ongoing Licensed nursing staff and nursing assistants will be re-educated on incidents/accident including but not limited to ensuring immediate interventions are patient specific i.e. neuro checks and change in transfer status, updating the Kardex and care plans. 4. The facility Director of Nursing/Designee will conduct a quality review on 10 residents of each unit (if applicable) X 5 days per week X 4 weeks, then weekly X 2 months, to ensure a complete and thorough investigation has been completed including but not limited to a completed root cause analysis, patient specific interventions have been initiated, completed, and placed in the patient's medical record, Kardex and care plans have been updated. Quality reviews will be forwarded to QAPI monthly until QAPI deems substantial compliance has been achieved and recommends quarterly reviews.	

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F 689	Continued From page 11 her transfer status along with her nursing care plan. The interview revealed NA #2 worked in the facility on a as needed (PRN) basis and relied on the Nurse Aide Kardex to care for the residents. Review of Resident #70's Nurse Aide Kardex care plan dated 12/17/21 revealed Resident #70 required a mechanical lift for all transfers. Review of a fall incident report dated 2/17/21 at 4:15 AM written by Nurse #2 revealed Resident #70 was assisted to the bathroom by one staff member NA #4. During the transfer from the wheelchair to the toilet Resident #70 started shaking and having tremors worse than normal. The Nurse Aide (NA) was unable to hold onto Resident #70 causing the resident to fall onto the floor and hit her head on the door to the bathroom. The report revealed no injuries were noted and immediate action included Resident #70 having a two staff member assistance with transfers. Review of a nursing progress note dated 2/17/21 at 4:15 AM written by Nurse #2 revealed NA #4 was assisting Resident #70 to the bathroom when the resident began to shake and experience tremors. NA #4 was unable to hold Resident #70, so she fell onto the floor hitting her head. The note revealed no injuries were noted and the incident was placed into the Physician's book for review. On 3/20/21 at 5:32 PM an interview was conducted with Nurse #2. During the interview she stated she was working on 2/17/21 when Resident #70 experienced a fall while one staff member assisted her to the restroom. The interview revealed she thought Resident #70 had	F 689	5. Completion date 5/7/2021.	

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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
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been a one-staff member assist with transfers but was now changed to a mechanical lift. The interview revealed she knew Resident #70 experienced tremors and shaking. Nurse #2 stated Resident #70 had hit her head during the fall, so she had initiated neuro checks following the incident. She stated nobody had told her Resident #70 was a two-person assist or mechanical lift for transfers prior to February 2021.

On 3/20/21 at 3:39 PM an interview was conducted with NA #4. During the interview she stated she was responsible for taking Resident #70 to the restroom by herself on 2/17/21. NA #4 stated Resident #70 had lost her balance and fell onto the floor hitting her head on the door of the restroom. The interview revealed she had taken care of Resident #70 prior to 2/17/21 and always used a one person assist with transfers however had learned since the incident that Resident #70 required a two-person assist and then was changed to a mechanical lift for transfers.

On 3/30/21 at 10:45 AM an interview was conducted with the Assistant Director of Nursing (ADON). She stated she was responsible for logging the incident reports into the computer system and taking the incidents into the daily morning clinical meeting for review. The interview revealed she could not remember discussing Resident #70's fall on 2/17/21 in morning meeting or noticing that she was transferred incorrectly which led to the fall itself.

On 3/30/21 at 5:07 PM an interview was conducted with the Director of Nursing (DON). During the interview she stated Resident #70 was currently a mechanical assist with transfers but

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F 689	Continued From page 13 from December to February the resident had required a two staff member assist with transfers. She stated she did not catch the incident that happened on 2/17/21 or notice the failure from the facility regarding one staff member assisting Resident #70. The interview revealed the Nurse Aide Kardex had not been updated to reflect the resident required a two staff member assist with transfers from December to February and the listing of mechanical lift was included on 3/11/21 but the date was not put on the Kardex so it looked like the resident was a mechanical lift on 12/17/20 when she wasn't. The DON stated NA #4 should have used at least a two staff member assist when transferring Resident #70.	F 689		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (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)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia,	F 693		5/7/21

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F 693	Continued From page 14 diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, resident and staff interviews, the facility failed to label and provide a tube feeding at the physician ordered flow rate for 1 of 1 sampled resident who received tube feedings (Resident #31). The findings included: Resident #31 was admitted to the facility on 3/21/21 with diagnoses that included dysphagia (difficulty swallowing), cerebrovascular disease and diabetes. A review of the Admission Minimum Data Set (MDS) assessment dated 3/26/21 indicated that Resident #31 was moderately cognitively impaired and exhibited coughing or choking during meals or when swallowing medications. Resident #31 received 51% or more of her total calories through tube feeding and an average fluid intake of 501 cc (cubic centimeters)/day or more by tube feeding. Resident #31's baseline care plan dated 3/21/21 indicated that Resident #31 was at nutrition and/or hydration risk due to feeding tube. The goal of Resident #31 having adequate fluid volume balance was listed. Interventions included weigh and record results, provide diet as ordered, observe for signs/symptoms of dehydration and report to nurse and supplements as ordered. A review of Resident #31's Medication Administration Record (MAR) for March 2021	F 693	1. Resident's # 31 feeding rate was immediately corrected. Resident # 31 was assessed by Director of Nursing on 3/29/2021 for any signs and symptoms of weight loss. 2. A quality review was conducted on current in-house residents X 7 days to ensure that feeding rates were accurate, external feeding bags were labeled and dated appropriately. 3.On 4/13/2021 and ongoing the Director of Nursing/Designee re-educated the licensed nurses on the labeling of external feeding bags, ensuring the accurate date, rate, and feeding is placed on the label. 4. The Director of Nursing/Designee will conduct a quality review of 5 residents (if applicable), 3 days per week X 4 weeks then weekly X 2 months, to ensure the correct order is in place and being followed, the external feeding bag is labeled with correct date, time, rate, and feeding. Quality Reviews will be forwarded to QAPI monthly until QAPI deems substantial compliance has been achieved and recommends quarterly reviews. 5. Completion date 5/7/2021.	

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revealed an active order dated 3/22/21 for Glucerna 1.5 continuous feeding at 30 ml (milliliters)/hour - start when available from pharmacy.

A review of Resident #31's medical record revealed an active order dated 3/24/21 for Glucerna 1.5 continuous at rate of 55 ml/hour for 22 hours with water auto flush of 30 ml/hour/22 hours; schedule 2-hour down time for showers/therapy.

An observation of Resident #31 on 3/28/21 at 10:07 AM revealed her gastrostomy tube (g-tube) connected to a continuous bag of feeding with about 200 ml left in the bag which was running at 55 ml/hour with standby bag of water at 900 ml level. The bag of feeding did not have a label. During the observation, an interview with Resident #31 revealed she did not know what kind of feeding she was supposed to get. Resident #31 stated she couldn't eat because she had swallowing issues but was able to swallow most of her medications.

A second observation of Resident #31 was made on 3/29/21 at 10:25 AM which revealed an unlabeled bag of tube feeding with about 500 ml left in the bag which was running at 30 ml/hour with a standby bag of water at 900 ml level.

An interview with Nurse #4 on 3/29/21 at 10:40 AM revealed the current order for Resident #31's tube feeding was for Glucerna 1.5 to run at 55 ml/hour x 22 hours, and then off x 2 hours, with 30 ml/hour of water flush every hour during the 22 hours that Glucerna was to run.

An observation was made with Nurse #4 on

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3/29/21 at 10:50 AM of Resident #31's tube feeding. Nurse #4 acknowledged that Resident #31's tube feeding had been running at 30 ml/hour, but it should have been set at 55 ml/hour. Nurse #4 stated she did not notice this rate when she went in earlier in the morning to give Resident #31's medications and that someone must have changed the settings on the feeding pump. Nurse #4 shared that Resident #31's tube feeding got started at 4:00 PM and then it ran throughout the night until 2:00 PM the next day. Nurse #4 also said that the bag of feeding should have been labeled with the resident's name, name of the feeding, date, and time it was started and at what rate it was supposed to run. She added that the bag set usually came with a sticker for the label to attach to the bag. During the interview, Nurse #4 re-set the feeding pump for Glucerna to run at 55 ml/hour and for the bag of water to run at 30 ml/hour.

Further observation of Resident #31 on 3/29/21 at 2:25 PM revealed her feeding pump had been turned off and disconnected from her g-tube. The bag of feeding that was previously running had been taken down.

A second interview with Nurse #4 on 3/29/21 at 2:26 PM revealed she had discontinued Resident #31's feeding as ordered at 2:00 PM and she noticed that there was about 200 ml of feeding left in the bag. Nurse #4 stated the bag of feeding was usually empty by the time she took it down at 2:00 PM.

A phone interview with Nurse #5 on 3/29/21 at 3:40 PM revealed she had worked with Resident #31 on the evening shift on both 3/27/21 and

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3/28/21. Nurse #5 remembered hanging and starting Resident #31's tube feeding of Glucerna 1.5 at 4:00 PM on both 3/27/21 and 3/28/21. She admitted to not placing a label to either bag on both days and said she didn't know she was supposed to at that time but after thinking about it, Nurse #5 stated it made sense to place a label on the bags and she should have done so. Nurse #5 also shared that there had been a big discussion on the night of 3/28/21 about Resident #31's tube feeding because she was confused about the order that was written on Resident #31's MAR. Nurse #5 stated she was not sure if Resident #31's tube feeding was supposed to be set at 55 ml/hour or 30 ml/hour, so she asked Nurse #6 who worked with her that night. Nurse #6 told her to set Resident #31's tube feeding at 30 ml/hour and so around 11:20 PM on 3/28/21, Nurse #5 went back to Resident #31's room and made sure her tube feeding was set to run at 30 ml/hour.

An interview with Nurse #6 on 3/29/21 at 4:10 PM revealed she remembered discussing with Nurse #5 about Resident #31's tube feeding rate around 10:30 PM on 3/28/21. Nurse #6 remembered from the week before that the physician wanted to switch Resident #31 from Jevity to Glucerna because the Jevity was running her blood sugar high. Nurse #6 remembered the order was for the Jevity to run 55 ml/hour but the order for the Glucerna was to run at 30 ml/hour. Nurse #6 remembered checking Resident #31's MAR with Nurse #5 and they saw the order for Glucerna 1.5 to run at 30 ml/hour. Nurse #6 also remembered Nurse #5 going back into Resident #31's room to make sure her tube feeding was running at 30 ml/hour before the night shift nurse arrived at the facility.

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F 693	Continued From page 18 An interview with Nurse #7 on 3/29/21 at 4:39 PM revealed Resident #31's most current order for Glucerna 1.5 was written on her chart on 3/24/21 for Glucerna 1.5 to run at 55 ml/hour. However, they did not receive the supply until after two days since it had been changed so they were still using Jevity at 55 ml/hour instead of Glucerna for two days. When they received the supply of Glucerna on 3/26/21, the order was not updated on Resident #31's MAR and they were still following the previously written order on 3/22/21 for Glucerna 1.5 to run at 30 ml/hour. Nurse #7 confirmed that Nurse #5 had followed the wrong order on Resident #31's MAR and should have run her Glucerna 1.5 feeding at 55 ml/hour. An interview with the Director of Nursing (DON) on 3/30/21 at 9:51 AM revealed there was confusion with Resident #31's feeding rate but the nurses should have checked the current order in her chart instead of relying on what was transcribed in the MAR. The DON confirmed that the new order for Resident #31's Glucerna did not get transcribed correctly in her MAR. She also stated that all bags of tube feedings should be labeled and dated whenever they were started. An interview with the Administrator on 3/31/21 at 5:39 PM revealed tube feedings should be labeled and given as ordered.	F 693		
F 761 SS=E	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	F 761		5/7/21

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F 761	Continued From page 19 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. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to date opened medication vials and discard outdated medications in 2 of 2 medication rooms (South and North) and 3 of 5 medication carts (blue, rehabilitation and silver). The findings included: The facility's policy entitled, "Storage of Medications," dated April 2007 indicated the following statements: * The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed.	F 761	1. On 3/31/2021 expired medications were immediately removed by the Director of Nursing. 2. On 4/12/2021 a quality review was conducted by the facilities pharmacy consultant on medication rooms, medication carts, and medication refrigerators. Issues or concerns were addressed as they were identified. 3.On 4/27/2021 and ongoing the licensed nursing staff will be re-educated by the Director of Nursing/Designee on the storage of drugs and biologicals to include but not limited to; the appropriate dating of medications, appropriate storage, and	

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F 761	Continued From page 20 * Medications must be labeled accordingly. a. An observation of the South medication room with Nurse #8 on 3/31/21 at 8:01 AM revealed an opened vial of influenza vaccine dated as having been opened on 10/12/20 in the medication room refrigerator. Less than half of the vial was left available for use. An opened and undated vial of tuberculin purified protein derivative (PPD) was also in the medication room refrigerator available for use. An interview with Nurse #8 on 3/31/21 at 8:02 AM revealed she was not sure when the influenza vial was last used but it should have been discarded after 28 days of opening. Nurse #8 stated the vial of tuberculin PPD should have been dated when it was opened because it was only good for 30 days after being opened. Nurse #8 shared that they used the tuberculin PPD to do a tuberculin skin test for new admissions and newly hired staff members, but she was unable to tell when it was last used or when it had been opened. b. An observation of the North medication room with Nurse #8 on 3/31/21 at 8:17 AM revealed an opened vial of tuberculin PPD dated as having been opened on 2/3/21 in the medication room refrigerator. Half of the vial was left available for use. An interview with Nurse #8 on 3/31/21 at 8:19 AM revealed the opened vial of tuberculin PPD should have been discarded after 30 days of opening. Nurse #8 stated the third shift nurses were supposed to be checking both medication rooms every night for undated and expired medications.	F 761	removal of expired meds. Licensed nurse will be trained to check their medication carts at the beginning of shift and at the end of shift for expired medications and the appropriate labeling of medications. 4. The Director of Nursing/Designee will conduct a quality review of the facility's medication carts/ medication rooms and medication refrigerators weekly X 6 weeks, then bimonthly X 3 months, to ensure all medications are dated, labeled appropriately, and non-expired. Quality Reviews will be forwarded to QAPI monthly until QAPI deems substantial compliance has been achieved and recommended quarterly reviews. 5.Completion date 5/7/2021.	

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c. An observation of the blue medication cart with Nurse #7 on 3/31/21 at 1:09 PM revealed an opened, undated, and unlabeled vial of Lidocaine. Half of the vial was left available for use.

An interview with Nurse #7 on 3/31/21 at 1:11 PM revealed that the vial of Lidocaine was not currently being used but it should have been labeled with the resident's name and dated when it was opened. Nurse #7 stated the opened vial of Lidocaine was only good for 28 days after being opened and because she couldn't tell when it was opened, she said it should have been discarded.

d. An observation of the rehabilitation medication cart with Nurse #7 on 3/31/21 at 1:17 PM revealed an opened Insulin Lispro pen available for use marked with Resident #31's handwritten name on the pen. It did not have a date to indicate when it was opened.

An interview with Nurse #7 on 3/31/21 at 1:19 PM revealed that the Insulin Lispro pen should have been dated when it was opened because it was only good for 28 days after opening. Nurse #7 could not tell when it had been last administered to Resident #31.

e. An observation of the silver medication cart with Nurse #9 on 3/31/21 at 1:30 PM revealed an opened Novolog pen available for use labeled with Resident #1's name and dated as having been opened on 2/1/21.

An interview with Nurse #9 on 3/31/21 at 1:32 PM revealed the opened Novolog pen was not currently being used and she doubted that the 2/1/21 on the label was the date it was opened

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F 761	Continued From page 22 because the order for Resident #1's insulin had been discontinued on 10/20/20. Nurse #9 stated someone must have put the wrong date on the pen, but it should have been discarded when Resident #1's insulin order was discontinued. An interview with the Director of Nursing (DON) on 3/31/21 at 4:43 PM revealed that all medications in the medication rooms and the medication carts should be labeled and dated and discarded when no longer in use. The DON shared the third shift nurses were supposed to be checking the medication rooms every night and the medication carts at least once a week, but all nurses were responsible for checking the medication carts that they were using for unlabeled and expired medications. An interview with the Administrator on 3/31/21 at 5:39 PM revealed the third shift nurses were responsible for checking the medication rooms and the medication carts at least once a week. The DON and the Assistant DON did audits on the medication rooms and the medication carts as well and should have made sure all opened vials were dated and all expired medications were discarded.	F 761		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted	F 842		5/7/21

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to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or

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F 842	Continued From page 24 (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to document neurological assessments in the medical record for 3 of 4 residents reviewed for falls (Resident #70, Resident #22 and Resident #25). The findings included: 1.Resident #70 was admitted into the facility on 04/02/19 with diagnosis which included seizures, neurological disorder, and osteoporosis. Review of Resident #70's most recent annual Minimum Data Set (MDS) dated 02/26/21 revealed she was severely cognitively impaired. Resident #70 required extensive two-person assistance with transfers, toilet use, personal hygiene, and bed mobility. Resident #70 was coded as having two or more falls since admission and no falls with injury or major injury.	F 842	1.On 3/30/2021 resident # 70, #22, and # 25's medical records were reviewed. The Director of Nursing immediately re-educated the licensed nurses that were on duty on initiating and completing neuro checks for unwitnessed falls and falls with head injuries. 2.On 4/12/2021 a quality review was conducted on in-house residents with a 60 day look back to review falls, to ensure a complete and thorough investigation has been completed to include appropriate intervention and follow-up. Issues or concerns were addressed as they were identified. 3.The Director of Nursing, Assistant Director of Nursing, and Administrator were re-educated on 4/21/2021 by the VP of Clinical Operation on the completion of an investigation to include but not limited	

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F 842	Continued From page 25 Review of a fall incident report dated 2/17/21 at 4:15 AM written by Nurse #2 revealed Resident #70 was assisted to the bathroom by one staff member NA #4. During the transfer from the wheelchair to the toilet Resident #70 started shaking and having tremors worse than normal. The Nurse Aide (NA) was unable to hold onto Resident #70 causing the resident to fall onto the floor and hit her head on the door to the bathroom. The report revealed no injuries were noted and Resident #70 was assisted back to her wheelchair via a two staff member assist. Review of a nursing progress note dated 2/17/21 at 4:15 AM written by Nurse #2 revealed NA #4 was assisting Resident #70 to the bathroom when the resident began to shake and experience tremors. NA #4 was unable to hold Resident #70, so she fell onto the floor hitting her head. The note revealed no injuries were noted and the incident was placed into the Physician's book for review. A review of the facility neurological assessment record in the Electronic Medical Record (EMR) indicated neurological assessments were supposed to be completed as follows and placed in the resident's chart: - every (q) 15 minutes 4 times - q 30 minutes 2 times - q 60 minutes 4 times - q 4 hours 6 times - q shift 2 times Review of Resident #70's Medical Record revealed no neurological assessments had been completed.	F 842	to; a root cause analysis, verifying immediate interventions are in place i.e. neuro checks and change in transfer status, verifying/updating the Kardex, care plans and validation that documentation is placed in patient's medical records. Licensed nursing staff and nursing assistants were re-educated by the Director of Nursing on 4/13/2021 and 4/15/2021 and ongoing to included but not limited to appropriate fall/transfer procedures with return demonstration. On 4/27/2021 and 4/29/2021 and ongoing Licensed nursing staff and nursing assistances will be re-educated on incidents/accidents including but not limited to ensure immediate interventions are patients specific i.e. neuro checks and change in transfer status, updating the Kardex and care plans. 4. The facility Director of Nursing/Designee will conduct a quality review on 10 residents of each unit (if applicable) X 5 days per week X 4 weeks, then weekly X 2 months, to ensure a complete and through investigation has been completed including but not limited to a completed root cause analysis, patient specific interventions have been initiated, Kardex and care plans have been updated. Review neuro-checks to ensure they are initiated and completed and ensure they are placed in the resident medical record. Quality Reviews will be forwarded to QAPI monthly until QAPI deems substantial compliance has been achieved and recommends quarterly reviews. 5. Completion date 5/7/2021.	

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On 3/30/21 at 1:09 PM an interview was conducted with Nurse #11. She stated she was assigned to Resident #70 at the time of her fall in which she hit her head on 2/17/21. The interview revealed she had obtained vital signs once she assessed the resident for injuries and placed the incident in the Physicians book for review. Nurse #11 stated Resident #70 hit her head during the fall, so she initiated neurological assessments per facility protocol. Resident #70's medical record indicated that no neurological assessments were completed after Resident #70's 2/17/21 fall, this information was reviewed with Nurse #11. Nurse #11 revealed that she had conducted at least 3 neurological checks for Resident #70 on 2/17/21, an initial check that occurred soon after the fall around 4:30 AM and subsequent checks following the incident. She indicated that there were no irregularities with the assessments. Nurse #11 was unable to explain why the neurological checks she said she conducted were not in the medical record.

During an interview with the Director of Nursing (DON) on 3/30/21 at 5:07 PM when asked about the facility's protocol for neurological checks she stated that the assigned nurse was to complete and document neurological assessments in the EMR at the following frequency: every (q) 15 minutes x 4, q 30 minutes x 2, q 1 hour x 4, q 4 hours x 6, and q shift x 2 for a resident who experienced a fall with head trauma. The neurological assessment record in the EMR dated 2/17/21 for Resident #70 indicated no assessments had been completed after her fall was reviewed with the DON. Nurse #11's interview in which she stated she completed 3 neurological assessments after Resident #70's fall was reviewed with the DON. The DON

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indicated that Nurse #11 should have documented the neurological assessments in the medical record per facility protocol.

2. Resident # 22 was admitted to the facility on November 18, 2010 with diagnoses which included Parkinson's, dementia, and muscle wasting with atrophy.

A review of the medical record revealed nursing documentation dated February 20, 2021 at 5:00 PM. The documentation by Nurse # 1 indicated she was notified by a Nurse Aide (NA) that Resident # 22 had sustained an unwitnessed fall in his room. Nurse # 1 noted the resident was "lying on his back with a moderate amount of blood in the floor beside his head." Further documentation showed a "lump" to the top of the head, a torn, bleeding mole on the left side of the head, and a laceration to the back of the head. There was no documentation in the nurses' notes indicating neurological checks (neuro checks) were performed on Resident # 22 after striking his head.

Review of Resident # 22's incident report dated February 20, 2021 timed 5:00 PM and completed by Nurse # 1, showed an unwitnessed fall from unknown surface with skin tears to top of head, left temple, back of head, and fractured right humerus. The report indicated that Resident # 22 was out of bed unassisted. Immediate actions taken showed ice to right humerus, skin tears cleansed, and dressings applied at 5:30 PM. The report showed the facility Nurse Practitioner (NP) was notified of the fall on 2/20/2021 at 5:30 PM. The resident's vital signs were documented as pulse of 90 beats per minute, respirations of 20

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per minute, and blood pressure of 144/90. There was no documentation of neuro checks on the incident report.

An interview with Nurse # 1 on March 28, 2021 at 3:56 PM revealed she remembered being called into Resident # 22's room due to a reported fall. On entry to the room, Nurse # 1 stated there was a small amount of blood on the floor near his head. Nurse # 1 stated "his head wasn't all that bad. He had some small cuts on the back of his head and on the side and front of his head." Nurse # 1 was asked if she performed neuro checks on Resident # 22. She stated, "I took his vital signs and checked him every 10 minutes." When asked if she documented any assessment or neuro checks on the Neurological Evaluation Flow Sheet, she stated, "No. I put them in my notes." After informing Nurse # 1 that no documentation of neuro checks was found in her notes, she stated, "There was a lot going on that night. I must have forgot."

An interview with the Director of Nursing (DON) on March 28, 2021 at 4:20 PM revealed she expected nurses to assess residents from head to toe following an unwitnessed fall. She also expected nurses to document neuro checks on the facility Neurological Evaluation Flow Sheet or in the nurse's notes. The DON complied with a request to review Resident # 22's medical record in search of documentation of neuro checks. The DON verified that no record of neuro checks was present in the medical record for February 20 - 21, 2021.

An interview with the Assistant DON (ADON) on March 30, 2021 at 10:45 AM revealed she expected nurses to complete the following actions

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after unwitnessed resident falls: head to toe assessment for injuries, notify Physician, obtain a resident statement of the fall, perform neuro checks every 15 minutes. She could not explain the lack of documentation of neuro checks for Resident # 22.

An interview with the Administrator on March 31, 2021 at 4:45 PM revealed she expected nurses to complete a full body assessment and neuro checks on any resident who had an unwitnessed fall. She stated she expected nurses to complete documentation of those assessments in the medical record. When asked to explain the lack of documentation, she stated, "we have work to do."

3. Review of incident report dated 01/09/21 revealed that Resident #25 had fallen out of her wheelchair and was sent to the hospital for an injury. Nursing staff heard Resident #25 yelling and found the resident lying in the floor. Resident #25 was transferred to her bed, and the medical director was notified.

Review of a Facility Reported Incident (FRI) dated 01/13/2021 and completed by the Director of Nursing (DON) revealed on 01/09/2021 Staff heard resident yelling for help, upon entering room resident observed lying on the floor face up and wheelchair flipped over. Resident reported that she was trying to get into wheelchair when the wheelchair rolled out from underneath her. Resident reported she could not stand or walk. New orders obtained to send to Emergency Department for evaluation and treatment related to fall.

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F 842	Continued From page 30 Review of Resident #25's medical record revealed no documentation of the neurological assessments. An interview on 03/30/2021at10:45 with the Assistant Director of Nursing (ADON) revealed following an unwitnessed fall the staff were expected to do neurological checks. The ADON indicated their neurological checks were documented on a separate sheet and placed in the chart and if there is not a sheet in the chart, neuro checks were probably not done. A follow up interview with Nurse #2 on 03/30/2021 at 4:40PM revealed her assessment consisted of "looking at the resident from head to toe and making sure not bleeding from anywhere and had no head injury, make sure can move arms, check hand grasps, make sure can straighten or lift legs, and make sure can sit up." She further indicated that neurological checks were completed but does not recall if neuro checks were documented or not.	F 842		
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	F 880		5/7/21

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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 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

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F 880	Continued From page 32 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 record reviews, observations and staff interviews, the facility failed to implement their infection control policies and the Centers for Disease Control and Prevention (CDC) guidelines for the use of Personal Protective Equipment (PPE) when 3 of 3 staff members (Nurse Aide #2, Nurse Aide #3 and Nurse #10) in the quarantine hall failed to wear eye protection and discard their masks after providing resident care to 2 of 2 residents (Resident #31 and Resident #72) reviewed for infection control. This failure occurred during a COVID-19 pandemic. The findings included: The Centers for Disease Control and Prevention (CDC) guidance entitled, "Preparing for COVID-19 in Nursing Homes," updated on 11/20/20 indicated the following statement under the section "Create a Plan for Managing New Admissions and Readmissions Whose COVID-19 Status is Unknown": *HCP (Healthcare personnel) should wear an	F 880	1.On 3/28/2021 the facility staff on duty were immediately re-educated by the Director of Nursing in infection control practices per the CDC specifically related to usage of eye protection during care and services of the resident and changing face mask between patients. 2.A quality review was conducted on infection control practices to ensure that staff were following CDC guidelines as related to the usage of Protective Personal Equipment for transmission-based precautions.Issues or concerns were addressed as they were identified. 3.On 4/13/2021 and ongoing the SDC re-educated the facility staff to include licensed nurses, non-licensed nursing, therapy department, dietary department, maintenance department, housekeeping and administrative on infection control compliance as it relates to the CDC	

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F 880	Continued From page 33 N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a face shield that covers the front and sides of the face), gloves, and gown when caring for these residents. The CDC guidance entitled, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic," updated on 2/23/21 indicated the following statements under the section "Recommended infection prevention and control (IPC) practices when caring for a patient with suspected or confirmed SARS-CoV-2 infection": * Disposable respirators should be removed and discarded after exiting the patient's room or care area and closing the door unless implementing extended use or reuse. * Put on eye protection (i.e., goggles or a face shield that covers the front and sides of the face) upon entry to the patient room or care area, if not already wearing as part of extended use strategies to optimize PPE supply. * Remove eye protection after leaving the patient room or care area, unless implementing extended use. * Reusable eye protection (e.g., goggles) must be cleaned and disinfected according to manufacturer's reprocessing instructions prior to re-use. Disposable eye protection should be discarded after use unless following protocols for extended use or reuse. A review of the facility's policy entitled, "Infection Control: Interim Policy for Suspected or Confirmed Coronavirus (COVID-19)," last revised on 12/15/20 indicated the following statements: * If disposable respirator is used, it should be	F 880	guidelines for the usage of personal protective equipment including but not limited to wearing eye protection during the delivery of care and services, changing facemask between the care and services of patients. The above describe in-service will be repeated by the DON the week of 4/27/2021 and ongoing.The facilities Quality Assurance and Performance Improvement Committee and governing body conducted a root cause analysis on 4/22/2021 to determine the cause of the facilities non-compliant practice, it has been determined that further education is needed on CDC guidelines for infection control. The facility staff will be re-educated monthly on CDC guidelines on infection control practices as it pertains to the usage of personal protection equipment and any updates and guidelines that the CDC sets forth concerning infection control practices. 4. The facility Director of Nursing/Designee will conduct a quality review on the quarantine unit 5 days per week X 6 weeks, then 3 days per week X 4 weeks, then monthly, to ensure CDC guidelines of infection control as it pertains to the usage of personal protective equipment. Quality Reviews will be forwarded to QAPI monthly until QAPI deems substantial compliance has been achieved and recommends quarterly reviews. 5. Completion date 5/7/2021.	

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removed and discarded after exiting the resident room and closing the door.
* Eye Protection that covers both the front and sides of the face. Remove before leaving resident room. Reusable eye protection will be cleaned and disinfected according to manufacturer's recommendation. Disposable eye protection will be discarded after use.

During a continuous observation on 3/28/21 from 9:15 AM to 10:29 AM of the quarantine hall, all resident doors had posted signage for enhanced droplet isolation precautions requiring mask, gown, gloves and face shield or goggles. Face shields were available on a table right before the entrance door to the quarantine hall. Plastic bins containing N95 masks, surgical masks, gowns, gloves, and disinfectant wipes were in the hallway outside the doors in the quarantine hall.

a. On 3/28/21 at 9:27 AM, Nurse Aide (NA) #2 was observed entering Resident #31's room after putting on a disposable gown and gloves. She was wearing an KN95 mask. She did not have a face shield or goggles on. At 9:43 AM, NA #2 removed her gown and gloves, exited Resident #31's room and used hand sanitizer out in the hallway. She was still wearing the same KN95 mask and no eye protective gear on when she left the quarantine hall.

An interview with NA #2 on 3/28/21 at 11:03 AM revealed she wasn't assigned to work on the quarantine hall, but she decided to help NA #3, so she went into Resident #31's room. Resident #31 wanted to get a bed bath which was what she did when she went into Resident #31's room. NA #2 stated she thought she didn't have to wear eye protection when going into rooms in the

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quarantine hall because the facility did not have any current COVID-19 positive cases. NA #2 also stated she wore the same KN95 mask when going in and out of resident rooms even in the quarantine hall. She usually discarded her mask after two consecutive days of working at the facility.

b. On 3/28/21 at 9:50 AM, NA #3 was observed putting on a disposable gown and gloves while wearing a KN95 mask. She was not wearing a face shield or goggles. She entered Resident #72's room while carrying linens and towels. At 9:59 AM, NA #3 exited Resident #72's room without a gown or gloves. She rubbed hand sanitizer to both hands while in the hallway. She still had the same KN95 mask on and did not have any eye protective gear on. At 10:00 AM, NA #3 was observed exiting the quarantine hall. On 3/28/21 at 10:29 AM, NA #3 put on a disposable gown and gloves, got linens off the linen cart and entered Resident #31's room to answer her call light. NA #3 was wearing a KN95 mask but did not have any eye protection on. At 10:30 AM, NA #3 exited Resident #31's room without a gown, gloves or eye protective gear on. She wore the same KN95 mask and rubbed hand sanitizer to both hands in the hallway.

An interview with NA #3 on 3/28/21 at 10:31 AM revealed that she was assigned to work on the quarantine hall as well as half of 200 hall. NA #3 stated she preferred to wear a KN95 mask because the N95 mask hurt her nose, but she did not discard it until the end of her shift. NA #3 stated nobody told her that she was supposed to change her mask when coming out of rooms in the quarantine hall. NA #3 also shared that she

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DEER PARK HEALTH & REHABILITATION	306 DEER PARK ROAD NEBO, NC 28761

(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 880	Continued From page 36	F 880		

used to wear a face shield when the facility had COVID-19 positive cases but did not think she had to when working with residents who had tested negative for COVID-19 including newly admitted and re-admitted residents in the quarantine hall.

c. On 3/28/21 at 9:51 AM, Nurse #10 was observed going into Resident #72's room to give her medications. Nurse #10 put on gloves and a disposable gown while carrying a medication cup into Resident #72's room. Nurse #10 was wearing a KN95 mask but did not have either face shield or goggles on. At 9:59 AM, Nurse #10 came out of Resident #72's room without gown, gloves or eye protection on. She still had the same KN95 mask on.

An interview with Nurse #10 on 3/28/21 at 2:45 PM revealed she was assigned to the quarantine hall which currently only had two residents. She was also assigned to 200 hall. Nurse #10 stated she usually discarded her KN95 mask at the end of the day and did not know she was supposed to switch it when going in and out of rooms in the quarantine hall. Nurse #10 also stated she used to wear eye protection when the facility had COVID-19 positive cases but did not think she had to wear one when working in the quarantine hall.

An interview with the Director of Nursing (DON) who oversaw infection control at the facility on 3/28/21 at 3:16 PM revealed staff was expected to wear full PPE which included a gown, face mask, gloves and goggles or face shield when working with residents in the quarantine hall. They were also supposed to take off their gown and gloves and discard them prior to leaving the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345233	A. BUILDING _____ B. WING _____	C 04/12/2021

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DEER PARK HEALTH & REHABILITATION	306 DEER PARK ROAD NEBO, NC 28761

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F 880	Continued From page 37 room, wash their hands, change out mask, disinfect their eye protective gear and do hand hygiene before going into another room or another area in the facility. The DON stated the facility had plenty of PPE available for staff to use. An interview with the Administrator on 3/31/21 at 5:39 PM revealed that she expected her staff to follow the infection control policies and procedures set forth by the CDC but she admitted that she would need to review the most recent updates from CDC because they were always changing.	F 880		