STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345164	A. BUILDING _____ B. WING _____	C 04/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOWAN RIVER NURSING AND REHABILITATION CENTER	1341 PARADISE ROAD EDENTON, NC 27932

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E 000	Initial Comments An unannounced Recertification survey was conducted on 4/26/21 through 4/30/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #2T5T11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 4/26/21 through 4/30/21. Event ID# 2T5T11. 11 of the 22 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 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.	F 550		6/1/21

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

Electronically Signed | 05/30/2021

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F 550	Continued From page 1 §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 observation, record review and staff interviews, the facility failed to treat a resident with dignity and respect by accusing the resident of lying for 1 of 1 cognitively impaired resident reviewed for dignity. (Resident #20) Findings included: Resident #20 was admitted to the facility on 11/22/2019 with diagnoses that included non-alzheimer's dementia and depression. Review of the Quarterly Minimum Data Set (MDS) dated 2/8/2021 revealed Resident #20 had severe cognitive impairment, required extensive assistance with one person for Activities of Daily Living (ADLS). Resident #20 was independent with locomotion in the wheelchair. During an observation on 4/26/2021 at 1:00 PM,	F 550	Chowan River Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Chowan River Nursing and Rehabilitation Center response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Chowan River Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of	

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F 550	Continued From page 2 Resident #20 was asked by NA #2 if she had finished eating her lunch. Resident #20 replied "yes". NA #2 entered the resident's room, looked at her lunch tray and asked Resident #20 "Why did you lie to me?" NA #2's tone was accusatory, and her facial expression was straight faced. Resident #20 had left 50% of the food on the meal tray. The Administrator was notified immediately, and NA #1 was pulled from the assignment. An interview was conducted with NA #2 on 4/26/2021 at 1:10PM. NA #stated she meant no harm and was just joking with Resident #20. During an observation of Resident #20 on 4/26/2021 at 1:20PM, the resident stated staff don't understand when I'm full. An interview was conducted with the Administrator o 4/26/2021 at 3:30 PM. The Administrator stated she expected residents would be treated with dignity and respect. The Administrator further stated education had been completed with NA#2.	F 550	Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F550 Resident Rights/Exercise of Rights CFR (s): 483.10(a)(1)(2)(b)(1)(2) On 4/26/2021, The Administrator in-serviced nursing assistant (NA) # 2 on effective communication and treating residents with dignity and respect. On 5/7/21, 100% resident interviews and education was initiated by the Social Worker with all alert and oriented residents in regards to Dignity and Respect/Resident Rights. The Unit Managers and Staff Facilitator will address all concerns identified during the interviews. Interviews will be completed by 6/1/21. On 4/26/2021, a 100% in-service was initiated by the Staff Facilitator with all staff to include NA # 2 in regards to Effective Communication. On 5/7/2021, a 100% in-service was initiated by the Staff Facilitator with all staff in regards to Resident□s Rights with emphasis on treating resident□s with dignity and respect. In-services will be completed by 6/1/21. All newly hired staff will be in-serviced by the Staff Facilitator during orientation regarding Effective Communication and Resident Rights.	

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F 550	Continued From page 3	F 550	The Medical Records Director, Unit Managers, Social Worker, Administrator and/or Activity Staff will monitor 10 staff interactions with residents to include nursing assistant # 2 weekly x 4 weeks then monthly x 1 month utilizing the Resident Rights Audit Tool. This audit is to ensure staff treat residents with dignity and respect during all interactions. The Staff Facilitator and/or Unit Manager will immediately address all areas of concern identified during the audit to include re-training of staff. The Director of Nursing (DON) will review and sign the Resident Rights Audit Tool to ensure completion and that all areas of concerns were addressed. The DON will forward the results of the Resident Rights Audit Tool to the Executive Quality Assurance (QA) Committee monthly x 2 months. The Executive QA committee will meet monthly x 2 months and review the Residents Rights Audit Tool to determine trends and/or issues that may need further interventions put into place and determine the need for further and/or frequency of monitoring.	
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which	F 580		6/1/21

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F 580	Continued From page 4	F 580		

results in injury and has the potential for requiring physician intervention;
(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct

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F 580	Continued From page 5 part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, staff, and physician interview the facility failed to notify the physician and responsible party that a resident developed a new pressure area for 1 (Resident #229) of 6 residents reviewed for pressure ulcers. The findings included: Resident #229 was diagnosed with COVID-19 and transferred to a COVID only facility on 1/19/21 and was re-admitted to the facility on 2/2/21. A Quarterly Minimum Data Set (MDS) Assessment dated 2/10/21 revealed the resident had moderate cognitive impairment and required extensive to total assistance with activities of daily living with the exception that she was able to feed herself with tray set-up. The MDS noted the resident was incontinent of bowel and bladder. It was noted the resident was at risk for pressure ulcer and had 1 unstageable pressure on admission and moisture associated skin damage. The MDS noted nutrition and hydration to manage skin conditions, a pressure reducing device for the bed and chair, pressure ulcer care and the application of non-surgical dressings. A Wound Ulcer Flow Sheet completed by the treatment nurse dated 3/11/21 revealed a stage II pressure ulcer on the resident's sacrum that measured 2.0 centimeters (cm) by 1.5 cm by 0.1 cm with a small amount of serous drainage, eschar and redness but no infection. It was noted	F 580	F580 Notify of Changes (Injury/Decline/Room, etc) CFR Resident # 229 no longer resides in the facility. On 5/14/21, the Director of Nursing initiated a review of all current residents with pressure ulcers. This audit is to ensure the physician and resident representative (RR) were notified of any new pressure wound, appropriate interventions were initiated per MD order/wound protocol, and order transcribe to the electronic treatment record. The treatment nurse will address all areas of concern identified during the audit to include assessment of the resident, notification of the physician and RR, initiation of appropriate interventions with documentation in the electronic record. Audit will be completed by 6/1/21. On 5/7/21, 100% in-service was initiated by the Staff Facilitator with all nurses in regards to Acute Change with emphasis on notification of the physician and resident representative with new or worsening wounds. In-service will be completed by 6/1/21. All newly hired nurses will be in-serviced by the Staff Facilitator during orientation in regards to Acute Changes.	

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F 580	Continued From page 6 that a treatment was initiated. The form under number 12 read: "MD (medical doctor) notification date" with no documentation the physician was notified. Number 13 on the flow sheet read "Responsible party notification date" with no documentation of notification. Number 13a on the flow sheet read: "Name of Responsible Party Notified" and had no documentation. The flow sheet noted a treatment was initiated. There were no progress notes that the physician or the responsible party was notified. On 4/28/21 at 9:42 AM an interview was conducted with the Treatment Nurse who stated on 3/11/21 one of the nursing assistants asked her to look at the resident and noted the new stage II wound and she initiated standing treatment orders. The Treatment Nurse further stated she had worked in the facility for 3 days at the time and was new and still learning and did not notify the doctor or the RP of the new Stage II pressure ulcer. On 4/28/21 at 1:49 PM the Director of Nursing (DON) stated in an interview when there was a new pressure ulcer the physician should be notified to get new orders for treatment even though they have standing orders for wounds. The DON continued and stated the RP should have been notified as well. On 4/29/21 at 2:50 PM an interview was conducted with the physician that cared for Resident #229 while in the facility. The Physician further stated he was aware the resident had some excoriation of the sacrum when re-admitted to the facility but when he saw the resident he was not able to see it very well and was not aware of any new skin breakdown.	F 580	On 5/7/21, 100% in-service was initiated by the Facility Consultant with the Administrator, Director of Nursing, and Minimum Data Set (MDS) nurse in regards to Tips for Wound Monitoring. In-service will be completed by 6/1/21. All newly hired Administrator, DON, and MDS nurse will be in-serviced during orientation in regards to Tips for Wound Monitoring. The Unit Manager and/or Minimum Data Set Nurse (MDS) will review Wound Report weekly x 4 weeks then monthly x 1 month to ensure the physician and resident representative have been notified of all newly identified and/or worsening pressure wounds. The Unit Managers and/ or Treatment nurse will address all areas of concern identified during the audit. The Director of Nursing will review and initial the Wound Report weekly x 4 weeks then monthly x 1 month to ensure all areas of concern were addressed. The DON will forward the results of the Wound Report to the Executive Quality Assurance (QA) Committee monthly x 2 months. The Executive QA committee will meet monthly x 2 months and review the Wound Report to determine trends and/or issues that may need further interventions put into place and determine the need for further and/or frequency of monitoring.	

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F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to protect the private health	F 583	F583 Personal Privacy/Confidentiality of Records	6/1/21

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F 583	Continued From page 8 information for 1 of 5 sampled residents (Resident #22) by leaving confidential information unattended and exposed in an area accessible to the public. Findings included: A continuous observation was conducted at 4/26/2021 at 12:25 PM thru 12:29 PM of an unattended medication cart (A Hall Medication Cart). There was a Medication Administration Record exposed on top of the cart which contained the resident's name (Resident #22), and other protected health information. There were multiple staff and residents on the hall. An interview was conducted with nurse #2 in 4/26/2021 at 12:29 PM. Nurse # 2 stated she thought she had locked the screen prior to walking away from the cart. The nurse stated she was aware that she was supposed to hit lock on the desktop before walking away from the cart. An interview was conducted with the Administrator on 4/26/2021 at 12:44 PM. The Administrator stated the resident's information should not have been visible when the nurse walked away.	F 583	On 4/26/21, the Staff Facilitator educated nurse #2 regarding protecting private health information by closing electronic medical record when left unattended in an area accessible to the public. On 5/11/21, 100% audit was initiated by the Director of Nursing, Unit Manager and Staff Facilitator to ensure all electronic medical records are closed and not exposing resident□s personal and private medical information when left unattended in an area accessible to the public. The Director of Nursing, Unit Manager and Staff Facilitator will address all concerns identified during the audit to include securing all resident private health information. Audit will be completed by 6/1/21. On 5/7/21, the Staff Facilitator initiated an in service with all nurses to include nurse #2 and Medication Aides regarding Privacy Acknowledgement Non-Disclosure Agreement with emphasis on closing electronic medical record when left unattended in an area accessible to the public. This in-service will be completed by 6/1/21. All newly hired nurses and Medication Aides will receive in-service regarding Protecting Private Health Information during orientation by the Staff Facilitator. The Unit Manager and/or Staff Facilitator will audit 100% of electronic medical records on the medication carts weekly x 4 weeks then monthly x 1 month using a	

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F 583	Continued From page 9	F 583	Medication Cart Audit Tool to ensure all electronic medical records are closed to protect private health information when left unattended in an area accessible to the public. The Unit Manager and/or Staff Facilitator will address all areas of concern identified during the audit to include re-education of staff. The Director of Nursing will review and initial the Medication Cart Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all areas of concerns were addressed. The Administrator will forward the results of the Medication Cart Audit Tool to the Executive QA Committee monthly x 2 months. The Executive QA Committee will meet monthly x 2 months and review the Medication Cart Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to	F 686		6/1/21

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F 686	Continued From page 10 promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, staff, registered dietician and physician interview the facility failed to implement a comprehensive approach to pressure ulcer care and services for a resident who was at risk for pressure ulcers for 2 (Resident #229 and Resident #34) of 6 residents reviewed for pressure ulcers. The findings included: 1. Resident #229 was admitted to the facility on 9/28/18 and had a diagnosis of diabetes mellitus, rheumatoid arthritis, cerebrovascular accident (stroke), anemia, hypertension and dysarthria. Dysarthria is a weakness in the muscles used for speech which often causes slowed or slurred speech. On 1/19/21 the resident was diagnosed with COVID-19 and transferred to a COVID only facility. The resident was re-admitted to the facility on 2/2/21. An admission progress note revealed the following: Was admitted from a sister facility COVID only. Excoriation to sacrum with blanchable redness. A pressure ulcer risk assessment dated 2/2/21 noted the resident was at high risk for pressure ulcers. Prevention interventions were documented as follows: Turning and repositioning. Moisturizer/cream. Barrier cream at bedside. Skin alterations: Left flank and coccyx - redness. A non-ulcer skin sheet dated 2/2/21 noted	F 686	F686 Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) Resident # 229 no longer resides in the facility. On 5/5/21, the treatment nurse assessed Resident # 34 sacral wound. Treatment was completed per physician orders. There was no change in wound status. Treatment nurse notified the physician and resident representative of current wound status. Resident #34 continues to follow with wound clinic. On 5/14/21, the Director of Nursing initiated a review of residents with current pressure ulcers to include resident #34. This audit is to ensure the physician and resident representative (RR) were notified of any new or worsening pressure wound, appropriate interventions were initiated per MD order/wound protocol, and the order transcribe to the electronic treatment record. The treatment nurse will address all areas of concern identified during the audit to include assessment of the resident, notification of the physician and RR, initiation of appropriate interventions with documentation in the electronic record. Audit will be completed by 6/1/21. On 5/7/21, 100% in-service was initiated by the Staff Facilitator with all nurses to	

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F 686	Continued From page 11 excoriation to the sacrum and the physician had been notified. Excoriation sacrum: 8 centimeters (cm) by 5 cm by 0.2 cm. The resident's Care Plan revised on 2/3/21 noted the resident was at risk for skin breakdown or development of pressure ulcers related to physical limitation. The interventions included the following: Staff to report to nurse any red or open areas. Pressure relieving mattress, float heels when in bed, turn and position frequently, use a draw sheet for turning if needed. The interventions included bunny boots to feet and heels and observe skin daily for any changes and report any abnormal observations. The Care Plan revealed the resident had excoriation to the buttocks. The interventions were to administer medications and treatment as ordered and to observe for changes in skin integrity or skin impairment and notify the physician as necessary. On 2/9/21 a progress note revealed there was the excoriation to the sacrum had healed and noted a physician's order to clean sacrum, pat dry with 4 by 4 gauze and apply (name of) dressing weekly. A Quarterly Minimum Data Set (MDS) Assessment dated 2/10/21 revealed the resident had moderate cognitive impairment. The MDS noted the resident required extensive assistance with bed mobility, was not ambulatory and required total assistance with dressing, toileting, personal hygiene, bathing and was able to feed herself after tray set-up. The MDS noted the resident had limited range of motion of both upper and both lower extremities and was incontinent of bowel and bladder. The resident's weight on the MDS was 166 pounds with no significant weight loss or gain. The MDS revealed	F 686	include the treatment nurse in regards to the Wound Process with emphasis on initiating interventions for new wounds, notification of the physician and resident representative, transcribing orders to the electronic treatment record timely, and documenting on the electronic treatment record after completion of treatment. In-service will be completed by 6/1/21. All newly hired nurses will be in-serviced by the Staff Facilitator during orientation in regards to the Wound Process. On 5/7/21, 100% in-service was completed by the Facility Consultant with the Administrator, Director of Nursing, and Treatment Nurse in regards to Treatment Nurse Tip Sheet for wound monitoring. The Unit Manager and/or Staff Facilitator will review Wound Report weekly x 4 weeks then monthly x 1 month. This audit is to ensure the physician and resident representative (RR) were notified of any new or worsening pressure wounds, appropriate interventions were initiated per MD order/wound protocol, order transcribe to the electronic treatment record, and documentation on the electronic treatment record after completion of treatment. The Unit Managers, Staff Facilitator and/ or Treatment nurse will address all areas of concern identified during the audit. The Director of Nursing will review and initial the Wound Report weekly x 4 weeks then monthly x 1 month to ensure all areas of concern were addressed.	

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F 686	Continued From page 12 the resident was at risk for pressure ulcers and had one unstageable pressure ulcer on admission and moisture associated skin damage. The MDS noted a pressure reducing device was used for the bed and chair and the resident received pressure ulcer care and the application of a non-surgical dressing. A note by the registered dietician (RD) dated 2/15/21 noted the following: Resident was admitted with COVID. PO (by mouth) intake approximately 50 percent of a regular diet. Name of nutritional drink 90ccs three times a day for prevention of weight loss. Pressure ulcer toe and excoriation of the sacrum. (Healed on 2/9/21). Interventions for wound healing: Multivitamin and name of protein supplement 30ccs twice a day. Albumin (Protein) level 2.9 (low). No edema reported at this time. Current body weight 164.4 pounds. Current diet order meets requirements. Wound healing interventions in place as well as intervention for the prevention of weight loss. Will continue to monitor. A physician's note dated 3/8/21 revealed the resident had intermittent episodes of mental status changes and a history of urinary tract infections. PO intake appears to be fairly stable overall. The note revealed the physician had been told the resident had some sacral excoriation versus breakdown being reported as excoriation versus unstageable sacral pressure wounds and possibly some eschar formation. No signs of infection or drainage or odor. The Physical Examination revealed the following. She is awake, alert and oriented at baseline. She definitely looks more chronically ill than she did prior to COVID. Mucous membranes are moist. Given her body habitus and assistance, I was not	F 686	The DON will forward the results of the Wound Report to the Executive Quality Assurance (QA) Committee monthly x 2 months. The Executive QA committee will meet monthly x 2 months and review the Wound Report to determine trends and/or issues that may need further interventions put into place and determine the need for further and/or frequency of monitoring.	

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able to completely visualize the sacral area. Notes from the treatment nurse noted to be sacral area approximately 5 by 8 cm area as well. (On admission, now healed). The Plan revealed the following: Continue the course for now, offloading, nutritional support. Certainly, need to trend and obtain accurate weights. Notify if any changes acutely. Notify of any changes acutely if any skin breakdown or changes acutely otherwise. Otherwise continue wound treatment with local wound protocol and nutritional support.

A Wound Ulcer Sheet dated 3/11/21 noted a new Stage II pressure ulcer on the sacrum that measured 2.0 cm by 1.5 cm by 0.1 cm with a small amount of serous drainage, eschar and redness but no infection. Cleanse with normal saline, pat dry and apply (name of) dressing. This dressing has calcium alginate and silver. The dressing is a highly absorbent dressing that protects the wound bed. The silver in the dressing helps to protect against infection. Section 12. MD (medical doctor) Notification Date was not filled out. There were no documentation in the progress notes that the physician had been notified of the new skin breakdown.

A Situational-Background-Assessment-Recommendations (SBAR) note dated 3/15/21 at 4:51 AM noted the following: Skin wound ulcer. Unresponsive. Vital signs: Blood Pressure (BP) 99/48. Temperature 99.8 degrees Fahrenheit. Pulse 80 irregular. Respirations 24. Apical heart rate 100. Most recent weight 150.5 pounds. Unresponsive, low BP, temperature and sacral decubitus. To ED for evaluation.

A nurse's progress note dated 3/15/21 at 4:51

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revealed the nurse went to the room to help the nursing assistant change the dressing and the resident was found to be unresponsive. BP 110/78. Temperature 99.8 degrees Fahrenheit. Pulse 88. Respirations 24. Apical pulse 100, Did sternal rub with no response. Physician notified and new orders given to send the resident to the hospital for evaluation. Resident left facility at 5:15 AM. Called to get report on resident and resident septic, urinary tract infection and decubitus. Resident to be admitted.

A progress note dated 3/16/21 at 5:09 PM that read: "N.O. (new order). Cleanse stage 2 sacrum wound with NS (normal saline), pat dry, apply (name of dressing). Measurements of wound 2x1.5x0.1 (2cm by 1.5cm by 0.1cm). Has eschar and redness around wound, upper sacrum has excoriation, barrier cream applied." This note was a late entry documented by the treatment nurse after the resident had been discharged to the hospital.

Review of the Emergency Department (ED) Record dated 3/15/21 at 5:36 AM revealed the following: A female that presents with unresponsiveness. BP 67/39. Temperature 100.6 degrees Fahrenheit. Pulse 104. Respirations 26. Weight 67.9 kilograms (149 pounds). Physical Exam: Patient appears pale, breathing on her own. Responds with grunting to sternal rub. Sacral decub (decubitus) with black eschar, purulent drainage noted in an area of the wound with palpation. Medical Decision Making/Plan: Presents unresponsive from nursing home, hypotension noted. Suspect sepsis. Urine possible source as well as sacral decubitus which is notable for purulent drainage.

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Laboratory (Lab) studies conducted in the ED included the following: COVID test negative. Serum White Blood Cell (WBC) count 29,000 (Normal range 4.5-11.0) indicating infection. Hemoglobin 9.7 (12.0-16.0). Hematocrit 29.7 (35.0-47.0). Sodium 138 (136-145). Potassium 3.8 (3.4-4.4). chloride 106 (98-102). Glucose 130 (70-105). Blood Urea Nitrogen (BUN) 39 (10-20). Creatinine 1.19 (0.57-1.11). Total Protein 5.6 (6.2-8.1). Albumin 2.3 (3.2-4.6). Urinalysis positive for infection. Urine Culture showed greater than 100,000 colonies per milliliter of Klebsiella Pneumoniae. One Blood Culture was negative at 5 days and one Blood Culture grew Enterococcus Faecalis.

The Admission History and Physical noted the following: In the ED was found to be febrile with temperature 100.6 degrees Fahrenheit. WBC 29,000. Hypotensive and elevated Troponin. Urinalysis suggested urinary tract infection (UTI). Head CAT Scan negative and chest x-ray showed pulmonary edema. Given intravenous fluids without improvement in the BP and started on a medication to increase the blood pressure. Patient also noted to have sacral decubitus that appeared to be infected. Due to septic shock, hospitalist asked to admit for further care.

The Hospital Discharge Summary noted the patient was brought to the ED due to unresponsiveness. Patient with infected sacral ulcer initially treated with broad spectrum antibiotics and pressors (medication to increase blood pressure) for septic shock. Family elected comfort care given her overall poor prognosis. Expired on 3/17/21 at 11:10 PM. Discharge diagnosis: Septic shock, Sepsis due to UTI. Unstageable sacral pressure ulcer. Wound

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infection, dementia, severe protein calorie malnutrition and MI (Myocardial Infarction or heart attack).

An interview was conducted with the Treatment Nurse on 4/28/21 at 9:42 AM who stated on 2/2/21 the resident had a excoriation of the sacrum when re-admitted to the facility. The Treatment Nurse stated the nursing assistants (NAs) would come and tell her if she needed to look at a skin issue and thinks one of the NAs got her to look at the new stage II wound for this resident on 3/11/21. The Treatment Nurse further stated she followed the standing orders for treatment but forgot to write the new order and she put in the order on 3/16/21. The Treatment Nurse continued and stated she had been working in the facility for about 3 days and was new and still learning and did not notify the doctor about the change in the resident's skin condition.

On 4/28/21 at 1:49 PM an interview was conducted with the Director of Nursing (DON). The DON stated they have a morning meeting with the department heads, including dietary and discuss changes in condition. The DON further stated any worsening of the wound the physician should be notified to get new orders for treatment even though they have standing orders for wounds. The DON stated the nurses were not required to do weekly skin assessments and the NAs were supposed to report any skin changes to the nurse daily.

On 4/29/21 at 12:25 PM a telephone interview was conducted with Medication (Med) Aide #1 who stated she worked first shift with the resident. The Med Aide stated she did not recall if the resident had any skin issues.

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An interview was conducted with Med Aide #2 on 4/29/21 at 12:40 PM. The Med Aide stated the resident had some skin issues when she returned from the COVID facility but did not recall if she developed anything new after that.
On 4/29/21 at 1:25 PM an interview was conducted with the Unit Manager (UM) who stated if there was not a treatment ordered she would not have seen her sacrum.

On 4/29/21 at 2:50 PM an interview was conducted with Nurse #1 who was assigned to the resident on night shift on 3/14-15/21 and sent the resident to the hospital. The Nurse stated she went in the resident's room around 5:00 AM during her medication pass and was unable to wake up the resident even with a sternal rub. The Nurse stated in report she had been told the resident had a sacral ulcer with some drainage and bleeding. The Nurse further stated the resident had a bowel movement and she assisted the NA to change the resident. The Nurse continued and stated when she first saw the wound the dressing had been removed due to soiling and there was no drainage or bleeding but she could not remember the appearance of the wound. The Nurse stated she checked the resident's blood sugar which was good and her vital signs were not bad but she called the doctor and got orders to send her out to the hospital. Attempts were made to interview other nurses and NAs that cared for the resident but either the staff member could not be reached or the staff member could not recall the resident.

On 4/29/21 at 2:50 PM an interview was conducted with the physician that cared for the resident while in the facility. The Physician stated he had seen a lot of COVID patients and

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afterwards the patient would hang in there for a little bit and then go downhill. The Physician stated he was not notified the resident was not consuming the supplements and was not notified of the resident's weight loss. The Physician further stated anytime a resident was not eating this could certainly contribute to the development of a pressure ulcer. The Physician continued and stated the resident had excoriation of the sacrum on admission but he was not able to see the area very well. The Physician stated when in the hospital a culture was not done of the resident's pressure ulcer and there was no debridement done. The Physician further stated her urine culture was correlated to her sepsis and when in the ED she was in congestive heart failure.
2. Resident #34 was admitted to the facility on 2/20/2020 with diagnoses that included musculoskeletal-arthritis and non-Alzheimer's Dementia.

A record review revealed a nurse note dated 2/17/2021 that indicated Resident #34 was readmitted from another facility on 2/17/2021.

A record review revealed an admission skin referral form dated 2/17/2021 that indicated Resident #34 had a stage III pressure ulcer to sacrum with a treatment of medi honey 6 X 6 proximal gauze.

A review of the most recent Annual Minimum Data Set (MDS) assessment dated 2/23/2021 revealed Resident #34 had severe cognitive impairment, was totally dependent on staff with one person assist for all Activities of Daily Living (ADLS). Resident #34 was incontinent of bowel and bladder, had a stage 3 pressure ulcer upon admission.

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A review of the resident care plan updated 2/20/2021 revealed a problem of ulceration or interference with structural integrity of layers of skin caused by pressure related to incontinence and immobility with a goal of Stage III to sacrum ... now a Stage IV would show positive healing with reduction in size of pressure ulcer through next review. The interventions included treatment as ordered by physician, monitor wound vac and alert nurse if not operating.

A review of the medical record revealed Resident #34 was seen by wound clinic on 3/12/2021 and returned to the facility with an order for a wound vac.

A review of the Treatment Administration Record (TAR) revealed an order to monitor wound vac at 125mmhg to sacrum stage IV pressure ulcer dated 3/12/2021. Further review of the TAR revealed that staff had been monitoring the wound vac each shift.

A review of the physician's orders for March 2021 revealed an order to change wound vac dressing every Monday, Wednesday, Friday and as needed to Stage IV sacral wound dated 3/17/2021.

A review of a grievance form dated 3/22/2021 revealed that a concern was identified with wound vac dressing changes. The grievance stated that the initial dressing was the same dressing that the resident appeared to the wound clinic with on 3/19/2021.

An interview was conducted with the wound doctor on 4/30/2021 at 10:21 AM. The physician

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stated Resident #34 was seen in the wound clinic on 3/12/21 and a wound vac order was placed. He stated that it was not uncommon for skilled nursing facilities to not have wound vacs available on day of the order. The wound doctor stated when Resident #34 returned to the wound clinic on 3/19/21 the wound vac had been placed. The doctor stated there had been no deterioration of the wound.

An interview was conducted with the wound nurse on 4/28/2021 at 3:49 PM. The wound nurse stated that Resident #34's wound vac was initiated on 3/12/2021. The wound nurse stated she had changed the wound vac on the next scheduled day 3/15/2021. The wound nurse stated when she went to change the wound vac on 3/15/2021, she knew it had to be changed three times a week, so she set the wound vac changes for Monday, Wednesday, Friday. The wound nurse stated she had put the wound vac order in a little late because she was just learning.

An interview was conducted with the DON on 4/28/2021 at 4:25PM. The DON stated she was not aware of any issues with the residents dressing when he went out to the wound clinic on 3/19/21. The DON stated that the Wound Nurse was responsible for changing the wound vac dressing. The DON stated resident returned from the wound clinic on 3/12/2021 with an order for a wound vac. The DON stated that she had assisted the wound nurse to place wound vac on 3/12/21 because there was one in the facility. The DON stated that she knew the wound nurse had changed the wound vac on 3/15/21 because the resident had gone to the shower and the wound vac dressing was completed afterwards by the

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F 686	Continued From page 21 wound nurse and she assisted. The DON further stated that on 3/19/21, the facility placed the wound vac dressing on resident because the wound clinic did not have the supplies.	F 686		
F 689 SS=G	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 review and staff and resident interviews, the facility failed to provide adequate supervision when repositioning a resident in the bed during care, resulting in the resident falling off the bed and sustaining an injury to her right arm for 1 of 4 residents (Resident #67) reviewed. The findings included: Resident #67 was admitted to the facility on 1/4/21 with diagnoses that included hypertension and arthritis. The admission Minimum Data Set (MDS) assessment dated 1/11/21 noted Resident #67 was cognitively intact and required extensive assistance with 1 person physical assistance for bed mobility. A review of Resident #67's Care Plan dated 1/4/21, with a focus are of Activities of Daily Living	F 689	Past noncompliance: no plan of correction required.	5/30/21

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care, revealed interventions to include bed mobility, one person assist.

Review of a nursing note dated 1/25/21 stated Nurse #2 was called to the room by NA #1 to find the resident was face down on the floor between the bed and the wall at 11:15AM.

Review of the fall report completed by Nurse #4 on 1/25/21 revealed Resident #67 had swelling and a small laceration to forehead. A small pool of blood was noted under head.

Review of a nursing note, by Nurse #4, dated 1/25/21 stated while receiving AM care, resident was turned to wash backside. In the process of turning resident rolled out of bed and fell approximately 3 feet to the floor. Resident landed face down. NA #1 called out for help. Resident was yelling out. Stated pain 7/10 to head, neck, and arms. Pressure applied to forehead. Dr. notified. 911 called.

Review of the Witness statement dated 1/25/21 by NA #1 stated "I went in the room to provide AM care. I turned the water on. I went to the resident and removed her gown. I unlocked the bed and pulled out from the wall and relocked it. I rolled resident to her left side. Resident was using the headboard to hold herself. I turned away from resident to get the water and heard the resident yell. I unlocked the bed to help reposition her and moved the bed and she fell to the floor. I yelled for help and moved the bed completely away from her as she was on the floor."

Review of the physician note dated 1/29/21 revealed Resident #67 required a foam cast to right arm due to a fracture of the distal end of the

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right humerus.

During an interview with Resident #67 on 4/27/21 at 11:48AM, she revealed she had fallen from the bed onto the floor. She further stated this occurred when NA #1 was providing care. Resident #67 stated she had broken her arm.

During an interview on 4/29/21 at 3:35PM with NA #1, she stated she had no recollection of the incident. A subsequent interview with NA #1 on 4/29/21 at 3:50PM revealed she was not familiar with Resident #67.

During an interview with Nurse #2 on 4/29/21 at 4:00PM revealed she had been called to Resident #67's room. When she arrived, the resident was on the floor. NA #1 stated the resident had fallen face first from the bed. The resident was yelling out in pain. Nurse #2 stated she assessed Resident #67. The PCP was notified and 911 was called. Resident was transported to the hospital. NA stated she had turned away from resident to get supplies, the resident was calling out, NA moved bed to re-position resident and resident fell from bed.

An interview with the Director of Nursing (DON) on 4/29/21 revealed NA #1 had difficulty with recall. The DON stated NAs were to place residents in the center of the bed during care and were not to leave the resident unattended during care.

The Corporate Compliance Nurse (CCN) #1 stated, on 4/29/21, that following this incident, all nursing assistant staff, 20 of 20, were re-educated on turning and positioning resident and safe handling and movement of residents.

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She further stated all nursing assistant staff were audited during the training to include observation and presentation. CCN #1 stated further random audits were conducted on a weekly basis to observe 10 nursing assistants, across all shifts, to ensure turning and positioning of residents was done correctly. She further stated NA #1 was re-trained on turning and positioning residents and safe handling and movement of residents. NA #1 was part of the random audits for 4 weeks, conducted by the Director of Nursing and the Unit Managers.

The facility provided the corrective actions dated 1/25/21, taken by the facility for tag F689 as follows:

" The corrective action for the alleged deficient practice was accomplished by:

Resident #67 was provided an assessment on 1/25/21. Resident #67 was observed to have small laceration with uncontrolled bleeding and swelling to the forehead and pain to the upper body. The Primary Care Physician was notified with orders to transfer resident to Emergency Department of local hospital for assessment. Resident's responsible party was notified by the licensed nurse of incident and transfer.

" Residents with the potential to be affected by alleged deficient practice:

The Unit Managers conducted an audit on 1/25/21 of 100% of all residents to ensure residents were positioned properly in bed. This audit identified no additional concerns.

" Systemic Changes:

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On 1/25/21, 100% Resident Care Audit on turning and positioning in bed with return demonstration was initiated by the Director of Nursing with all nursing assistants. This audit was to ensure staff used appropriate technique with turning and positioning during care and to ensure residents were positioned in the center of the bed following care. The Unit Managers and Staff Facilitator will address all areas of concern identified during the audit to include education to staff and/or repositioning resident when indicated. Return demonstrations was completed by 1/29/21.

On 1/25/21, the Director of Nursing (DON) initiated an in-service with all nursing assistants (NAs) to include NA #1 in regard to the Turning and Positioning with emphasis on positioning resident in the center of the bed during and following care to prevent falls/injury. In-service was completed by 2/2/21.

All newly hired NAs would be in-serviced by the Staff Facilitator during orientation in regard to Turning and Positioning.

" QAPI:

Ad Hoc QAPI was held on 1/25/21 and Performance Improvement Plan (PIP) was developed and accepted by the Inter-Disciplinary Team (IDT) on 1/26/21.

Quality Assurance Monitoring occurred once a week for 4 weeks to include an audit by the Staff Facilitator and Unit Manager utilizing the Resident Care Audit - Turning and Positioning. The audit ensured staff used proper technique for turning and positioning and that residents were

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F 689	Continued From page 26 positioned in the center of the bed during and following care. The Staff Facilitator addressed all concerns identified during the audit which included repositioning the resident and re-education of the Staff. The DON reviewed and initialed the Resident Care Audits - Turning and Positioning weekly for 4 weeks to ensure completion and that all areas of concern were identified. The DON forwarded the results of the Resident Care Audit Turning and Positioning Tool to the Executive QA Committee monthly for 1 month. The Executive QA Committee met monthly for 1 month and reviewed the Resident Care Audit Turning and Position Tool to determine trends and/or issues that may have needed further interventions put into place and to determine the need for further and/or frequency of monitoring. As part of the validation process of 4/29/21, it was verified that that audits were completed on all residents. It was further confirmed and reviewed that all nursing assistants were in-serviced on turning and positioning residents. The Quality Assurance monitoring was corroborated and validated. Date of Correction Action Completion. Final Compliance date 2/26/21 was verified and accepted.. Observations from 4/26/21 - 4/29/21 revealed residents were turned and positioned properly during incontinence care and wound care. The observations further revealed residents were positioned in the center of the bed following care.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance	F 692		6/1/21

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F 692	Continued From page 27 CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review, staff, registered dietician and physician interview the facility failed to do weekly weights and failed to identify and intervene for a significant weight loss for 1 of 11 residents reviewed for nutrition (Resident #229). The findings included: Resident #229 was admitted to the facility on 9/28/18 and had a diagnosis of diabetes mellitus, rheumatoid arthritis, hypertension, cerebrovascular accident (stroke), anemia and dysarthria. Dysarthria is a weakness in the muscles used for speech which often causes	F 692	F692 Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) Resident # 229 no longer resides in the facility. On 5/12/21, the facility consultant initiated a review of current resident weights from 3/1/21-5/12/21. This audit was to identify any resident with significant weight loss is to ensure appropriate interventions were initiated to include but not limited to weight monitoring per facility protocol and that the physician and resident representative	

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F 692	Continued From page 28 slowed or slurred speech. On 1/19/21, Resident #229 was diagnosed with COVID-19 and sent to a COVID only facility. The resident was re-admitted to the facility on 2/2/21. Admission assessments dated 2/2/21 noted the resident was at a high risk for pressure ulcers and had excoriation of the sacrum with blanchable redness and a suspected deep tissue injury (SDTI) on top of the toe. The resident's admission orders included a nutritional supplement 90 cubic centimeters (ccs) three times a day and a protein supplement 30ccs twice a day. The resident's weight was documented as 168.7 pounds on 2/4/21. The Quarterly Minimum Data Set (MDS) Assessment dated 2/10/21 revealed the resident had moderate cognitive impairment. The MDS noted the resident required extensive assistance with bed mobility, was not ambulatory and required total assistance with personal hygiene, bathing and toileting but was able to feed herself after the tray was set up. The MDS revealed the resident had impaired range of motion of both upper and both lower extremities. The resident's weight was 166 pounds with no significant weight loss or gain. The MDS noted the resident received a mechanically altered diet and was at risk for pressure ulcers and had one unstageable pressure ulcer present and moisture associated skin damage. The MDS revealed the resident received nutrition and hydration to manage skin conditions. A note by the dietary manager (DM) dated 2/10/21 read: "Mild cognitive impairment and	F 692	(RR) were notified of any significant weight loss. The Dietary Manager, Unit Managers and/or Staff Facilitator will address all areas of concern identified during the audit to include assessment of the resident, notification of the physician and RR, initiation of appropriate interventions with documentation in the electronic record and weight monitoring per facility protocol. Audit will be completed by 6/1/21/21. On 5/7/21, 100% in-service was initiated by the Staff Facilitator with all nurses in regards to Acute Change with emphasis on initiating interventions for weight loss and notification of the physician and resident representative. In-service will be completed by 6/1/21. All newly hired nurses will be in-serviced by the Staff Facilitator during orientation in regards to Acute Changes. On 5/7/21, 100% in-service was initiated by the Facility Consultant with the Administrator, Director of Nursing, Minimum Data Set (MDS) nurse, and dietary manager in regards to Tips for Weight Monitoring. In-service will be completed by 6/1/21. The Unit Manager and/or Staff Facilitator will review Weight Exception Report weekly x 4 weeks then monthly x 1 month. This audit is to ensure the physician and resident representative have been notified of all newly identified significant weight loss and appropriate interventions initiated to include but not limited to referral to	

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F 692	Continued From page 29 dysarthria. HOH (hard of hearing). Will voice needs at times. Dependent on staff for daily decision-making skills." On 2/11/21 the resident's weight was 164.4 pounds. A note by the DM dated 2/11/21 read: "Added snack in between meals. Added weekly weights. PO (by mouth) intake improved since last assessment." The resident's Care Plan revised on 2/12/21 noted the resident required assistance with eating related to rheumatoid arthritis of the hands. The Care Plan directed staff to set up the meal tray and provide a built-up utensil. The Care Plan noted the resident was at risk for altered nutrition related to would leave 25 percent or more uneaten at most meals. The interventions included the following: Diet as ordered. Assess food preferences. Set up tray and encourage consumption of meals. The Care Plan noted the resident was at risk for skin breakdown due to physical limitations and that staff were to report red or open areas and a dietary consult if nutritional status declined. A note by the registered dietician (RD) dated 2/15/21 noted the resident was admitted with COVID and was on a regular diet with PO intake approximately 50 percent and received a nutritional supplement three times a day for prevention of weight loss. It was noted the resident had a pressure ulcer to the right toe and excoriation of the sacrum. Interventions for wound healing included a multiple vitamin and a protein supplement 30ccs twice a day for a low albumin level of 2.9. The resident's current body	F 692	physician to review nutritional status to reduce risk of pressure wounds, re-weights, supplements, vitamins, labs, increased weight monitoring, RD referral, Speech therapy referral and appetite stimulant when indicated. The Unit Managers, Dietary Manager and/ or Staff Facilitator will address all areas of concern identified during the audit. The Director of Nursing will review and initial the Weight Exception Report weekly x 4 weeks then monthly x 1 month to ensure all areas of concern were addressed. The DON will forward the results of the Weight Exception Report to the Executive Quality Assurance (QA) Committee monthly x 2 months. The Executive QA committee will meet monthly x 2 months and review the Weight Exception Report to determine trends and/or issues that may need further interventions put into place and determine the need for further and/or frequency of monitoring.	

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weight was 164.4 pounds. The RD noted the current diet order met dietary requirements. Wound healing interventions in place as well as intervention for prevention of weight loss. Will continue to monitor at this time.

The meal documentation for the resident for February 2021 revealed the resident consumed 50-75 percent of most meals with 25 percent of 12 meals consumed and 4 meals refused.

The resident's weight on 3/4/21 was recorded under the weight section as being 150.5 pounds (10.79 percent weight loss in one month). There were no further weights or dietary notes for the resident after this weight was recorded.

A physician's note dated 3/8/21 revealed the following: "Subjective: Overall, has been doing fair. PO intake appears to be fairly stable overall. She does not appear to be malnourished or dehydrated. Physical Examination: I think she is probably oriented times 2 (person and place). She definitely looks more chronically ill than she did prior to COVID. Mucous membranes are moist. Plan: At this point, continue the course for now, offloading, nutritional support. Certainly, need to trend and obtain accurate weights. Notify if any changes acutely."

A Situation-Background-Assessment-Recommendation (SBAR) notation in the progress notes dated 3/15/21 at 4:51 AM noted the following: Unresponsive. Blood Pressure 99/48. Temperature 99.8 degrees Fahrenheit. Pulse 80 and irregular. Respirations 24. Apical heart rate 100. Most recent weight 150.5 pounds. Unresponsive, low Blood Pressure, temperature

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and sacral decubitus. To ED for evaluation.

A progress note dated 3/15/21 at 4:51 AM noted the resident was unresponsive and was sent to the hospital for evaluation. It was noted the hospital was called for a report on the resident and the resident was septic (blood infection) had a urinary tract infection and a pressure ulcer and was to be admitted.

Review of the resident's meal intake sheet for March 2021 revealed the resident consumed 50 percent of most meals, 75 percent of 6 meals, 25 percent of 5 meals and refused 5 meals.

In the Emergency Department the resident's initial vital signs were as follows: Temperature 100.6 degrees Fahrenheit. Blood Pressure 67/39. Pulse 104. Respirations 26. Weight 67.9 kilograms (149 pounds).

The hospital Discharge Summary dated 3/17/21 noted the resident was admitted with an infected sacral ulcer treated with broad spectrum antibiotics and pressors (medication to increase blood pressure) for septic shock. It was noted the septic shock was due to a urinary tract infection. The family elected comfort care given her overall poor prognosis. The resident expired on 3/17/21 at 11:10 PM.

An interview was conducted with the dietary manager (DM) on 4/28/21 at 1:14 PM. The DM was observed to review the weight record for Resident #229 and stated this one got by her. The DM further stated she reviewed the weight sheets and if there was a weight loss she put in a consult to the registered dietician (RD) The DM continued and stated she would put the weights

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on the weight sheet for the nursing assistants (NAs) to do the weekly weights and when the NAs brought the sheets back she would put the weights in the resident's electronic medical record. The DM stated she thought this resident refused some of her weights. The DM stated she would check the weight sheets.

On 4/28/21 at 1:49 PM an interview was conducted with the Director of Nursing (DON) who stated they have a morning meeting with the department heads, including dietary and discuss changes in condition. The DON further stated the doctor should have been notified of the weight loss and a consult put in with the registered dietician to see what she recommended when the resident showed a weight loss on 3/4/21.

An interview was conducted with the DM on 4/29/21 at 8:37 AM. The DM stated when a resident was admitted or re-admitted to the facility the nurse would weigh the resident and document the weight in the resident's electronic medical record. The DM further stated that weekly weights were done on all new admissions for 4 weeks. The DM continued and stated she would give the list of residents to be weighed to the restorative nursing assistant (RNA) to do the weights and would return the weight sheets to her and she (the DM) would document the weights in the electronic medical record. The DM stated they had weekly weight meetings where they discussed residents with weight loss, wounds and those that were not eating well. The DM further stated Resident #229 was not eating well when re-admitted to the facility and did not know if the resident was consuming the nutritional supplements. The DM continued and stated she did not put this resident's name on the weekly

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weight sheet and did not know what happened or what she did with the weight on 3/4/21. The DM stated she did not recall if this weight on 3/4/21 was discussed in the weekly weight meeting.

On 4/29/21 at 8:55 AM an interview was conducted with the DON who stated during the weekly weight meeting they look at the weight sheets and discuss weight loss and if a nursing assistant reports a resident is not eating well they discussed this in the meeting. The DON further stated she could not recall what was going on with this resident but would check her notes from the weight meeting. The DON provided no additional information regarding the resident's weight loss.

On 4/29/21 at 9:55 AM the DM stated she did not have any weekly weight sheets for Resident #229.

On 4/29/21 at 12:17 PM an interview was conducted with the facility's consulting registered dietician (RD). The RD stated she saw Resident #229 when she returned from the COVID facility and she had nutritional supplements in place. The RD stated she did not receive a consult from the facility for this resident in March 2021.

An interview was conducted with Medication (Med) Aide #1 on 4/29/21 at 12:25 PM. The Med Aide stated she worked first shift in the facility. The Med Aide stated Resident #229 was not eating and she would try to feed the resident, but she did not want to eat. The Med aide further stated the resident also refused the nutritional supplements and she would let the nurse know who would go in and check on the resident.

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An interview was conducted with Med Aide #2 on 4/29/21 at 12:40 PM. The Med Aide stated she worked the evening shift with this resident. The Med Aide stated when she came back from the COVID facility she was not the same and not as alert. The Med Aide further stated the resident was not eating that much, maybe 25-50 percent and would take the protein supplement but the resident told her the nutritional drink was too sweet.

The Unit Manager (UM) stated in an interview on 4/29/21 at 1:25 PM the staff were documenting the resident was not eating or drinking well and on her rounds she would offer the resident something to drink and she would drink a little but not much. The UM further stated she would try to assist the resident with eating and the resident would say she did not want it.

On 4/29/21 at 1:43 PM an interview was conducted with Nurse #1 who was working on the night shift and sent Resident #229 to the hospital on the morning of 3/15/21. The Nurse stated during her medication pass at 5:00 AM she went in and she was unable to wake up the resident even with a sternal rub. The Nurse continued and stated the resident's blood sugar was good and her vital signs were not bad but she called the doctor and got orders to send her out to the hospital.

On 4/29/21 at 12:25 PM an interview was conducted with the administrator and the DON. The DON stated if a resident had weight loss she would expect the resident to be re-weighed and to follow-up and if there was a significant weight loss she would expect a RD consult.

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F 692	Continued From page 35 On 4/29/21 at 2:50 PM an interview was conducted with the physician that cared for the resident while in the facility. The Physician stated he had seen a lot of COVID patients and afterwards the resident would hang in there for a little bit and then go downhill. The Physician stated he was not notified the resident was not consuming the supplements and was not aware of the resident's significant weight loss.	F 692		
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to have a Registered Nurse (RN) in the building for 8 hours a day, 7 days a week for 1 day of 3 months reviewed. The findings included: The nurse staffing sheets were reviewed for January, February and March 2021. On Saturday 1/9/21 there was not a RN scheduled to work.	F 727	F727 RN 8 hrs/7 days/wk./Full Time DON CFR(s): 483.35(b)(1)-(3) On 4/26/21, the Administrator and the Director of Nursing reviewed the staffing schedule for 4/26/21-5/5/21 to ensure the facility had sufficient registered nursing coverage per the Medicare Guideline to provide nursing care to all residents in accordance with resident care plans.	6/1/21

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F 727	Continued From page 36 An interview was conducted with the Director of Nursing (DON) on 4/29/21 at 4:56 PM. The DON stated she did not have RN coverage in the building on 1/9/21. The DON further stated she was out with COVID-19 and returned to work on 1/11/21 and a RN from a sister facility was covering but was not in the building and they had an interim administrator at the time.	F 727	On 5/5/21, the Facility Consultant reviewed the clinical staffing schedule for the past 30 days to ensure sufficient staff were on duty to meet the care needs of the residents. The Accounts Payable addressed all areas of concern with staff posting for RN coverage. On 5/7/21, the Facility Consultant initiated an in-serviced with the Administrator, Director of Nursing and Administrative Nurses in regards to Medicare Guideline on Register Nurse Coverage. This in-service emphasis on the requirement of 8 hours of consecutive registered nursing Coverage on a 24 hour basis to provide nursing care to all residents in accordance with resident care plans and to ensure the facilities ability to provide needed care to residents that enable them to reach their highest practicable physical, mental and psychosocial well-being. In-service will be completed by 6/1/21. Beginning 5/14/21, The Administrator and/or Director of Nursing will review the daily clinical staffing needs 24 hours prior to the scheduled worktimes to ensure the clinical staff are on duty to meets the needs of the residents to include eight (8) consecutive hours of registered nursing coverage. The Director of Nursing, Administrative Nurse and/or Administrator will review staffing schedule daily x 4 weeks then monthly x 1 month utilizing the Sufficient RN Coverage Audit Tool to ensure the	

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F 727	Continued From page 37	F 727	facility had 8 consecutive RN coverage per the Medicare Guideline to provide nursing care to all residents in accordance with resident care plans. The Director of nursing, Administrative Nurse and/or Administrative staff on Duty will address all concerns identified to include but not limited to notification of the Administrator and obtaining required nursing coverage. The Administrator will review the Sufficient RN Coverage Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all areas of concern were addressed. The DON will forward the results of Sufficient RN Coverage Audit Tool to the Executive Quality Assurance Performance Improvement Committee (QAPI) monthly x 2 months. The Executive QAPI Committee will meet monthly x 2 months and review the Sufficient RN Coverage Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F 761		6/1/21

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F 761	Continued From page 38 §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 observation and staff interview, the facility failed to discard expired medication for 1 of 2 medication carts (C Hall cart) reviewed for medication storage. The findings included: An observation was conducted of the C Hall medication cart on 4/28/2021 at 4:49 PM. One Advair discus had an opened date of 3/8/2021. The manufacturer's label stated discard 28 days after opening. An interview was conducted with the Medication Aide #3 and the Unit Manager on 4/28/2021 at 4:55 PM. The Unit Manager stated that the Advair Discus was to be thrown out 28 days after being opened. An interview was conducted with the DON on 4/28/2021 at 5:01 PM. The DON stated that the	F 761	F761 Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) On 4/28/21, the Administrative nurse removed expired medication from medication cart # C and medication replacement ordered and delivered 4/29/21. On 5/5/21, 100% audit of all medication carts was completed¿¿¿¿¿¿ by the Administrative Nurses to ensure no expired medications were stored in the medication carts, medications dated when opened per facility protocol, no medications or personal items were stored on top of the cart and that all carts were locked when not supervised by assigned nurse. There were no additional concerns identified.	

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F 761	Continued From page 39 Advair Discus was to be discarded 28 days after opening.	F 761	On 5/7/21, the staff facilitator initiated an in-servicer with all nurses and medication aides (MA) to include MA # 3 and Unit Manager in regards to Medications Storage. Emphasis included (1) checking medications before administration for expired dates and appropriately discarding expired medications per pharmacy policy, (2) dating medications when opened per facility protocol (3) ensuring cart is locked when not in use or directly supervised by assigned nurse. In-service will be completed by 6/1/21. All newly hired nurses and medication aides will be in-serviced by the Staff Facilitator during orientation in regards to Medications Storage. The Administrative Nurses and MDS nurse will monitor medication carts weekly x 4 weeks then monthly x 1 month utilizing the Medication Cart Audit Tool. This audit is to ensure no expired medications were stored in the medication carts, medications dated when opened per facility protocol and that all carts were locked when not supervised by assigned nurse. The Administrative Nurses will address all areas of concern identified during the audit to include re-education of staff. The DON will review and initial the Medication Cart Audit Tool for completion and to ensure all areas of concerns were addressed weekly X 4 weeks then monthly x 1 month. The Administrator will forward the results of Medication Cart Audit Tool to the Executive Quality Assurance Performance	

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F 761	Continued From page 40	F 761	Improvement Committee (QAPI) monthly x 2 months. The Executive QAPI Committee will meet monthly x 2 months and review the Medication Cart Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain kitchen equipment clean and in a sanitary condition by failing to clean 2 of 2 ice machines and failed to clean the reach-in freezer filter grill. The findings included:	F 812	F812 Food Procurement, Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) On 4/29/21, the Maintenance Supervisor cleaned the ice machine on the 300 Hall	6/1/21

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F 812	Continued From page 41 A review of the Dietary Policy Manual (Revised on 2/9/16) Under Cleaning Procedures; Ice Making Machines. Exterior: reads as: Clean heavily soiled surfaces with a mild cleaning solution, then rinse with clear water and air dry. Observation on 4/26/21 at 2:53 PM the 300-hall ice machine was observed to have lime build up under the lid frame and rust was visible on the hinge screws. No debris or rust was observed in the ice. A second observation on 4/29/21 at 10:03 AM revealed the 300-hall ice machine to be in the same condition. On 4/29/21 At 10:28 AM the dining room ice machine was observed to have lime build up under the lid frame and dust particles on top of the door. No debris or rust was observed in the ice. During the meal observation on 4/28/21 at 11:40 AM the 3-door freezer filter grill was observed. The freezer filter grill was observed to have a thin layer of grease and debris on the front of the grill. During a second observation with the Dietary Manager on 4/29/21 at 10:22 AM revealed the freezer filter grill to be in the same condition. In an interview on 4/29/21 at 10:23 AM the Dietary Manager confirmed the freezer filter grill needed to be cleaned. She stated the maintenance man cleaned the ice machines and she would have staff clean the reach in freezer grill immediately. In an interview on 4/29/21 at 10:30 AM the maintenance man revealed he cleaned the ice machines once a month, however he was unable to provide a date when they were last cleaned.	F 812	and in the Dining area. Hinge screws were cleaned on the ice machine located on 300 Hall. On 5/24/2021, the Maintenance Director removed and cleaned the reach-in freezer filter grill. On 5/6/21, The Dietary Manager initiated an audit of all kitchen equipment to include the reach-in freezer filter grill at the bottom of the freezer using a Kitchen Checklist. The Dietary Manager will address all areas of concern identified during the audit to include immediate cleaning of equipment and education of staff. Audit will be completed by 6/1/21. On 5/5/21 a 100% In-service was initiated by the Facility Consultant for the Dietary Manager, Dietary Aides, Cooks, and Dietary Manager Assistant regarding ensuring kitchen equipment is cleaned and kept in a sanitary condition and the policy, procedure and cleaning schedule for checking and cleaning kitchen equipment. In-service will be completed by 6/1/21. All newly hired dietary employees to include Dietary Managers, Dietary Assistants, Dietary aides and Dietary cooks will be in-serviced regarding ensuring kitchen equipment is cleaned and kept in a sanitary condition and the policy, procedure and cleaning schedule for checking and cleaning kitchen equipment during orientation by the Dietary Manager. On 5/5/21, the Administrator in-serviced	

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F 812	Continued From page 42 In an interview on 4/29/21 at 10:39 AM the Administrator stated if an area was listed to be cleaned then she expected the kitchen staff to clean it.	F 812	the maintenance staff in regards to Cleaning of Ice Machines. All newly hired maintenance staff will be in-serviced during orientation in regards to Cleaning of Ice Machines. The Social Worker and/or Accounts Receivable will check the reach-in freezer filter grill at the bottom grate of the freezer for cleanliness and the all ice machines to include ice machine on 300Hall and in the Dining area utilizing a Kitchen Audit Tool weekly for 4 weeks then monthly for 1 month. The Administrator will review and initial the Kitchen Audit Tool to ensure completion and that all areas of concerns were addressed weekly for 4 weeks and monthly for 1 month. The Administrator will present the findings of the Kitchen Audit Tool to the Executive Quality Assurance (QA) Committee monthly x 2 months. The Executive QA Committee will meet monthly for 2 months and review the Kitchen Audit Tool to determine the need for any trends or further frequency of monitoring.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control	F 880		6/1/21

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F 880	Continued From page 43	F 880		

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 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

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F 880	Continued From page 44 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 observation, record review and staff interview the facility failed to implement its personal protective equipment policy when Laundry Aide #1 failed to perform hand hygiene and change gloves before entering and exiting 3 of 3 resident rooms (Resident #1, 45, 14) observed for infection control practices. Findings included: A review of the facility's policy "Personal Protective Equipment" revealed that hand hygiene was performed before donning gloves and after removal, and gloves were not a substitute for hand hygiene. A continuous observation was made on 4/27/2021 at 8:51 AM to 9:12 AM. While gloved, Laundry Aide #1 was seen entering Resident #1's room. The Laundry Aide gathered the dirty laundry from room with her gloved hands, pulled	F 880	F880 Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) On 4/27/21, the Director of Nursing and Infection Preventionist immediately in-serviced all laundry staff to include Laundry Aide #1 in regards to changing gloves and sanitizing hands when removing soiled linen from each resident room. On 5/12/21, the Infection Preventionist initiated 100% return demonstrations with all staff to include laundry aide # 1 in regards to handwashing/glove use with emphasis on removing gloves and washing/sanitizing hands between resident rooms/contact. Audit will be completed by 6/1/21. On 5/21/21, cleaning of high touch areas	

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F 880	Continued From page 45 the door handled to close room door, and proceeded to the dirty linen pushcart where she deposited the laundry. There was no removal of gloves and no hand hygiene was performed. While gloved, the Laundry Aide knocked on door to Resident #45's room and entered. The Laundry Aide removed the dirty linens from the room and deposited the linens into the dirty linen pushcart. The Laundry Aide did not remove her gloves and no hand hygiene was performed. Laundry Aide #1 pushed the dirty linen pushcart to the next room. While gloved, Laundry Aide #1 knocked on the door to Room #14's room and entered. The Laundry Aide removed the dirty linens from the room and deposited the linens into the dirty linen pushcart. The Laundry Aide did not remove her gloves and no hand hygiene was performed. An interview was conducted with Laundry Aide #1 on 4/27/2021 at 9:15 AM. Laundry Aide #1 stated that she did not change gloves or wash hand between residents when picking up residents' dirty laundry. An interview was conducted with the Administrator on 4/27/2021 at 9:18 AM. The Administrator stated she expected that the laundry aide would have changed her gloves and washed hands in between residents.	F 880	was completed under the oversight of the Housekeeping Supervisor of rooms for resident #1, #14 and #45. On 5/7/21, the Infection Preventionist initiated an in-service with all staff to include Laundry Aide #1 in regards to Standard Precautions with emphasis on sanitizing hands and changing gloves between resident rooms/contact. In-service will be completed by 6/1/21. On 5/20/21, the Infection Preventionist initiated an in-service with all staff in regards to Handling Laundry. In-service will be completed by 6/1/21. All newly hired staff will be in-serviced during orientation in regards to Standard Precautions and Handling Laundry by the Infection Preventionist. Facility leadership staff to include the Infection Preventionist and/or Unit Managers will complete 10 staff observations to include Laundry Aide #1 utilizing the Handwashing/Glove Use Audit Tool weekly x 4 weeks then monthly x 2 months to ensure staff are sanitizing/washing hands and changing gloves between resident rooms. The Unit Managers and Infection Preventionist will address all areas of concern identified during the audit to include re-education of staff. The DON will review the Handwashing/Glove Use Audit Tool weekly x 4 weeks then monthly x 2 month to ensure all areas of concern were addressed.	

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F 880	Continued From page 46	F 880	The Director of Nursing will present the findings of the Handwashing/Glove Use Audit Tool to the Executive Quality Assurance (QA) Committee monthly x 3 months. The Executive QA Committee will meet monthly for 3 months and review the Handwashing/Glove Use Audit Tool to determine the need for any trends or further frequency of monitoring.	
F 914 SS=E	Bedrooms Assure Full Visual Privacy CFR(s): 483.90(e)(1)(iv)(v) §483.90(e)(1)(iv) Be designed or equipped to assure full visual privacy for each resident; §483.90(e)(1)(v) In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to provide curtains that provided full visual privacy for ten (10) of forty (40) rooms observed. (Room # ' s 132, 134, 144, 111, 127, 148, 121, 124, 140, and 143). 1. During an observation on 4/27/21 at 11:00 AM the privacy curtains were observed to be too short in Room 132 to allow full privacy if both residents in the room required care in the room at the same time. During an observation on 4/28/21 at 2:47 PM the privacy curtains were observed to be too short in	F 914	F914 Bedrooms Assure Full Visual Privacy CFR(s): 483.90(e)(1)(iv)(v) On 4/30/21, the Unit Manager, Admission Coordinator and Staff Facilitator initiated an 100% observation of all privacy curtains utilizing a resident census to ensure curtains provided full visual privacy. The Housekeeping Supervisor will addressed all areas of concern identified during the audit to include correctly installing curtains to provide full visual privacy and/or ordering replacement curtains as indicated to	6/1/21

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 914	Continued From page 47 Room 134 to allow full privacy if both residents in the room required care in the room at the same time. During an observation on 4/28/21 at 2:50PM the privacy curtains were observed to be too short in Room 144 to allow full privacy if both resident in the room required care in the room at the same time. An observation on 4/28/21 at 2:57PM the privacy curtains were observed to be too short in Room 111 to allow full privacy if both residents in the room required care in the room at the same time. During an interview with the Housekeeping Manager on 4/29/21 at 3:15PM, she revealed curtains should provide full visual privacy. She further stated housekeeping staff were responsible to notify the manager if the curtain did not provide full visual privacy. The Housekeeping manager noted the privacy curtain did not extend to provide full visual privacy for the residents. She stated she had not been notified by staff. During tour with the Maintenance Man on 4/29/21 at 3:35 PM, he confirmed the need for more curtains in the room. In an interview on 4/29/21 at 5:27 PM the Administrator stated staff should have made a manager aware, sections of the privacy curtains were missing, and they would make sure the curtains provided full visual privacy. 2. An observation on 4/27/21 at 12:46PM noted that the privacy curtain for Room #127 did not go completely around bed B. There was approximately 60 inches of insufficient privacy	F 914	provide full visual privacy. Audit will be completed by 6/1/21. On 5/11/21, the Administrator notified the Environmental Services Consultant requesting replacement of privacy curtains for all rooms identified during the audit to include rooms 132, 134, 144, 111, 127, 148, 121, 124, 140, and 141. Replacement curtains will be installed by 6/1/21. 100 % in-service was initiated on 5/7/21 by the Staff Facilitator with Housekeeping Manager and Housekeeping staff in regards Privacy Curtains with emphasis on checking privacy curtains after cleaning to ensure new curtain placed provides full visual privacy. In-service will be completed by 6/1/21. All newly hired housekeeping staff will be in-serviced during orientation in regards to Privacy Curtains. 100 % in-service was initiated on 5/7/21 by the Staff Facilitator with all nurses and nursing assistants in regards to Privacy Curtains with emphasis on when providing care the privacy curtain must provide full visual privacy and to notify Housekeeping Supervisor for any curtain that does not provide full visual privacy. In-service will be completed by 6/1/21. All newly hired nurses and nursing assistants will be in-service by the Staff Facilitator during orientation regarding Privacy Curtains. 100% of all resident rooms with privacy curtains, to include rooms 132, 134, 144,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345164	A. BUILDING _____ B. WING _____	C 04/30/2021

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F 914	Continued From page 48 curtain. This would not allow full visual privacy when the resident was receiving care or when the resident desired privacy. During an observation on 4/27/21 at 1:31PM, it was revealed Room #148 did not provide privacy to the resident in bed A. The privacy curtain did not extend around the bed nor was there another means to achieve privacy for the resident while receiving care or when the resident desired privacy. Observations on 4/29/21 at 2:15PM revealed Room #121, 124, 140, & 143 did not provide full visual privacy for the resident in bed B. The privacy curtain did not extend around the bed nor was there another means to achieve privacy for the resident while receiving care or when the resident desired privacy. There was approximately 60 inches of insufficient privacy curtain. During an interview with the Housekeeping Manager on 4/29/21 at 3:15PM, she revealed curtains should provide full visual privacy. She further stated housekeeping staff were responsible to notify the manager if the curtain did not provide full visual privacy. The Housekeeping manager noted the privacy curtain did not extend to provide full visual privacy for the residents. She stated she had not been notified by staff. An interview on 4/29/21 at 5:27PM with the Administrator stated staff should have made a manager aware that sections of the privacy curtains were missing. She further stated the facility would make sure the curtains provided full visual privacy.	F 914	111, 127, 148, 121, 124, 140, and 141, will be audited by the Social Worker, Accounts Receivable, Activities staff, Payroll, and/or Admission Director utilizing a resident census weekly x 4 weeks then monthly x 1 month to ensure that the privacy curtains provide full visual. The Housekeeping Supervisor will immediately address any identified areas of concern during the audit. The Administrator will review the resident census weekly x 4 weeks then monthly x 1 month to ensure all areas of concern were addressed. The Administrator will forward the results of the Privacy Curtain Audit/resident census to the Executive QI Committee monthly x 2 months. The Executive QI Committee will meet monthly x 2 months and review the Privacy Curtain Audit/resident census to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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