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	345529	A. BUILDING _____ B. WING _____	C 04/01/2021

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UNIVERSAL HEALTH CARE/NORTH RALEIGH	5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616

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E 000	Initial Comments The survey team entered the facility on 3/22/21 to conduct a Recertification and Complaint Survey. The survey team was onsite 3/22/21 through 3/26/21. Additional information was obtained offsite 3/27/21 through 4/1/21. Therefore, the exit date was 4/1/21.. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 9QHD11	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 3/22/21 to conduct a Recertification and Complaint Survey. The survey team was onsite 3/22/21 through 3/26/21. Additional information was obtained offsite 3/27/21 through 4/1/21. Therefore, the exit date was 4/1/21. Immediate Jeopardy was identified at CFR 483.25 at tag F-684 at a J. Immediate Jeopardy began on 3/24/21 and was removed on 3/26/21. F684 constituted Substandard Quality of Care. An extended survey was conducted. 5 of 42 complaint allegations were substantiated with a deficiency. Event ID: 9QHD11	F 000		
F 550 SS=G	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.	F 550		5/4/21

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

Electronically Signed | 04/26/2021

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F 550	Continued From page 1 §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. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews, the facility failed to provide pants for 1 of 3 residents reviewed for dignity. Resident #42 stated he was embarrassed, felt	F 550	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of	

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F 550	Continued From page 2 bad and didn't like it. Finding included: Resident #42 was admitted to the facility on 09/20/20 with diagnoses that included Parkinson 's Disease, cerebral infarction, asthma, hypertension and anxiety A review of Resident #42's quarterly minimum data set (MDS) dated 04/15/21 indicated the resident had no short/long term memory loss. Cognitive skills for daily decision-making was coded as being independent with some difficulty in new situations only. The resident needed extensive one-person assistance with dressing. A review of Resident #42's care plan dated 12/17/20 indicated he needed assistance with bed mobility, transfers, walking, dressing, toilet use and bathing. Interventions included staff to give verbal cues to help prompt the resident. The care plan did not identify Resident #42 refused care and treatment or would remove clothing. During an interview with Resident #42 on 03/22/21 at 12:10 pm, Resident #42 indicated his only concern at the facility was he had no clothes and the resident indicated he was embarrassed to talk to the surveyor because he only had on a shirt and adult brief. Resident #42 stated he was not able to go to the laundry department and get his clothes like some of the other residents. He added this really made him feel bad that his clothes were in the laundry and he didn't like not having any pants on. He indicated this had been going on for days and he had reported this but unsure what staff he told. During this interview Resident #42 gave surveyor permission to look in	F 550	deficiencies, or of any violation of regulation. F550-Respect, Dignity/Right to have Personal Property 1. Resident #43□s clothing was returned to him when they had been washed and dried, which was on 3/24/21. The resident□s care plan was updated on 4/29/21 by the Minimum Data Set (MDS) Coordinator to reflect he removes his clothing and often will refuse to wear clothing. Additionally, the care plan will reflect the resident will transfer himself prior to staff assisting with morning care (bathing, dressing, incontinent care. Resident #43□s clothing was returned when they were washed and dried. The Social Worker (SW) educated the resident, on 4/29/21, that due to safety reasons, he should not transfer himself independently. The SW also educated the resident to inform her or the Administrator if there were any concerns with receiving his clothing after the clothing had been laundered (24-48 hours) or if he was left without adequate clothing which placed him in a humiliating or undignified manner. The SW also educated the resident that if he had transferred himself and was sitting in a brief with his door shut that was fine while he remained in a private room. Additionally, the SW told the resident if someone should enter the room and he was embarrassed because he was sitting in a brief, he had the right to request that person leave his room.	

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F 550	Continued From page 3 his closet which revealed one shirt. A second closet in the room revealed nothing was in it. No pants were observed on Resident #42 during the interview. Resident#42 was observed in his room with the door slightly open on 3/22/21 at 12:10 pm with a shirt and an adult brief on; his lap was not covered. Resident #42 indicated that he was embarrassed to talk with surveyor, but he wanted his clothes. Resident #42 had no roommate. Resident #42 was observed at 2:30pm on 03/22/21 asleep in his wheelchair; his door was still slightly open. The resident had on a shirt and adult brief and his lap was not covered. During an interview with Nursing Assistant (NA) #8 on 03/23/21 at 9:30 am she indicated she had been working on the same hall for months and provided care for Resident #42. NA #8 stated the resident was able to provide most of his activities of daily living and was not aware of any concerns. NA #8 indicated nothing about Resident #42's clothing. During an interview with the Administrator on 03/24/21 at 2:30pm, she indicated no knowledge of Resident #42 missing clothes. The Administrator stated she would investigate the situation. She stated she expected the staff would treat all residents with dignity and ensure residents needs were provided for them. During an interview with Laundry Manager (LM) on 03/30/21 at 2:34 pm he indicated the concerns regarding Resident #42's clothes were reported to him on 3/24/21. The LM stated he went to the laundry department on 03/24/21 and brought the	F 550	2. All residents are at risk of having clothing not returned promptly after laundering or not having sufficient clothing provided by their family members. On admission the Admission Coordinator will determine if the facility and/or family will provide laundry services. Additionally, the Admissions Coordinator will request that all laundry be labeled with the resident□s name. If a resident enters the community without sufficient clothing, the facility will provide clothing that has been taken from donated items. Residents identified with behaviors of removing clothing, refusing to being dressed in clothing or transferring prior to being assisted with dressing will have the problem identified on the care plan by the MDS nurse. Nursing staff will address the behaviors with the individual resident and notify the responsible party about the behaviors. After admission, the assigned Ambassador (an assigned staff member that visits the resident daily, Monday through Friday, to handle any concerns verbalized by the resident, or observed by the Ambassador on the daily visits) will speak with the resident and/or the responsible party to determine if there had been any issues with having laundry returned promptly. 3. On 3/24/21, laundry staff were educated by Administrator to return clothing to residents either on the day of laundering or as soon as possible after the completion of laundering (24-48 hours). During morning administrative rounds (visits to assigned residents by administrative staff), Monday through	

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F 550	Continued From page 4 residents clothes to his room two days after the observations.	F 550	Friday, ambassadors (staff members assigned to one or more residents to assist with concerns) will ask alert and oriented residents if clothing had been returned from the laundry promptly. The ambassadors will also check the closets of all residents that are cognitively impaired during the visits. When someone that is cognitively impaired does not have clothing to wear; the ambassador will call the laundry for items to be returned/or the RP if no clothing items are available and discuss options. Results of the ambassador rounds will be discussed during the morning meeting and any concerns will be addressed promptly by the laundry supervisor and/or the Administrator. The Director of Housekeeping and Laundry or an assigned housekeeping staff member will complete weekly audits x 4 weeks, 3 x a week x 4 weeks and weekly x 4 weeks with 5 alert and oriented residents and/or resident representatives to assure compliance is achieved and maintained (this would be 1 resident or resident representative from each of the 5 halls). The audits started on 3/24/21. Nursing assistants (NAs) were educated by the Unit Coordinators starting on 4/29/21. Education included letting the SW, Unit Coordinator or the Administrator know if any resident had no clothing. The NAs were also instructed to find clothing in the donated clothing section of the laundry room if possible. Education also included teaching about dignity and not leaving any residents□ brief exposed, but to cover the resident with a gown or a sheet, if the	

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F 550	Continued From page 5	F 550	resident will allow staff to cover them. Education will be completed by 4/30/21. 4. Results of the audits will be presented to the community□s Quality Improvement/Performance Improvement Committee each month.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)-	F 656		5/4/21

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F 656	Continued From page 6 (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to develop an individualized person-centered care plan that addressed the resident need for activities of daily living (ADL) care and pressure ulcers. This occurred for 1 of 3 residents (Resident #29) reviewed for ADL care and pressure ulcers. Findings included: Resident #29 was admitted to the facility on 1-6-21 with multiple diagnosis that included congestive heart failure, chronic obstructive pulmonary disease, pressure ulcer and muscle weakness. Review of Resident #29's care plan dated 1-11-21 revealed no goals or interventions for activities of daily living (ADL) care or her pressure ulcer. The admission Minimum Data Set (MDS) dated 1-13-21 revealed Resident #29 was moderately cognitively impaired and needed extensive assistance with 2 people for bed mobility and personal hygiene, extensive assistants with one	F 656	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. F 656 DEVELOP/IMPLEMENT COMPREHENSIVE CARE PLAN. The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights. 1. Resident #29 discharged to home with a planned discharge on 3/24/21. 2. Any resident admitted to the community and requiring assistance with activities of daily living (ADLs) or having pressure wounds are at risk of not having goals and interventions included on their care plans. 3. Members of the IDT team and the Resident Care Coordinators (RCC) were	

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F 656	Continued From page 7 person for dressing, eating and toileting, and total assistance with 2 people for transfers and bathing. Resident #29 was also coded for 2 unstageable pressure ulcers acquired prior to admission. During an interview with the MDS nurse on 3-24-21 at 5:13pm, The MDS nurse discussed that she started the MDS position in February 2021 and did not know why Resident #29's care plan was not completed accurately. She stated she was able to audit resident care plans, but she had not had the opportunity. The Administrator was interviewed on 3-25-21 at 9:19am. The Administrator explained there had been a turnover in the department and there was a lack in the process for completing care plans.	F 656	educated on the timely completion of the comprehensive care plan that includes measurable objective and timeframes to meet a resident's medical, nursing, and mental psychosocial needs identified in the comprehensive assessment. The education was completed on 3/24/21 by the Administrator. The RCC audited 100% of resident care plans to identify any residents to assure ADLs and pressure ulcers were addressed as needed to include measurable goals and interventions. The audit was completed on 3/29/21. Any care plan missing required information were updated by the RCCs. The care plan for new admissions will be reviewed at the clinical meeting the day after admission on Monday through Friday and on Monday for any resident admitted on Friday, Saturday or Sunday by the Interdisciplinary Care Team (IDT). This audit began on 3/29/21. The IDT consists of the Director of Nursing (DON) and/or Unit Coordinators (UC) along with the Social Worker(s), Therapy Representative and Activity Director. Goals and interventions will be added for ADLs and/or pressure wounds as needed during the clinical meeting by one of the IDT members. Care plans for existing residents, going forward, will be reviewed by the IDT quarterly, annually and with any significant change in condition. Any needed revisions or additions will be made to the care plan as needed by a member of the IDT. The DON, UM or RCCs will randomly audit 3 resident care plans per week x 4 weeks, then 2 care plans per week x 4 weeks and then 1	

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F 656	Continued From page 8	F 656	resident care plan per week for 4 weeks. 4. Results of the care plan audits will be presented to the Quality Improvement/Performance Improvement Committee monthly by the Director of Nursing or the Unit Coordinator	
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interviews, and physician interview, the facility failed to provide care according to the assessment which required specific interventions in the care plan and supervision of the resident during meals. Resident #10 was observed unsupervised during 2 meals, and during one of the meals he was observed to be coughing, gasping for air, and had cereal/mucus exiting from his nasal passages. This was evident for 1 of 8 residents reviewed for activities of daily living (Resident #10). Immediate Jeopardy began on 3-24-21 when observation revealed Resident #10 without supervision from staff during a meal and was observed to be coughing, having difficulty	F 684	1. Resident #10 was evaluated by his physician on 3/25/21 and found without signs and symptoms of aspiration. The physician informed staff he had reviewed the speech therapist□s recommendations and found he had signed those recommendations on 2/26/21 and continued to agree with the recommendations that indicated Resident #10 was safe to eat independently. The physician stated he had not been apprised of the speech therapist□s recommendations when asked the question re: following the care plan for Resident #10; therefore, his answer to the question was given with incomplete information. On 3/25/21 resident #10	5/5/21

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F 684	Continued From page 9	F 684		

breathing, and was expelling food and mucous through his nasal passages. Immediate Jeopardy was removed on 3-26-2021 when the facility implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of "D" (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) to complete employee education and ensure monitoring systems in place are effective.

Findings included:

Resident # 10 admitted to the facility on 6/2/20 and readmitted to the facility on 9/24/20 with a history of cerebrovascular accident, oropharyngeal dysphagia, aphasia, and gastroesophageal reflux disease.

A quarterly Minimum Data Set dated 1/4/2021 revealed Resident #10 was severely cognitively impaired and required supervision (oversight, encouragement, or cueing) with 1-person physical assist with eating. Further review of Resident #10's swallowing/nutritional status of the MDS revealed he received a mechanically altered diet during the assessment period.

Review of Resident #10's care plan dated 10/1/2020 revealed the resident had swallowing difficulties and the goal was to have decreased choking episodes. The interventions were to supervise all oral intake, remind to tuck chin when swallowing, remind to alternate food and fluids, refer to speech therapy as needed, monitor assistance needed with swallowing and notify the provider of changes and thicken liquids (honey) thick. There was not an update or revised care plan since the 10/1/2020 care plan.

received a chest x-ray which indicated no signs of aspiration. Resident #10 also completed his swallowing evaluation test on 3/26/21 that was conducted by Dysphasia Management Systems (DMS). Vital signs were increased to every 4 hours for the named resident x 24 hours, to include auscultation of lung sounds and oxygen saturation. These measurements will be recorded on the resident's medication administration record and/or in the resident's electronic medical record. The speech therapist will continue to treat per the results of her evaluation and plan of care that was previously established. The resident's physician assessed the resident on 3/25/21 and found the resident to be without signs and symptoms of aspiration or any ill-effects from the alleged choking episode. The physician also reviewed the evaluation and plan of care for the resident, developed by the speech therapist, on 3/25/21 and agreed with the therapist's recommendations and plan of care that indicated the resident was safe to eat independently. The resident's care plan and care card were reviewed and revised by the Regional Nurse Consultant to reflect the named resident would receive 1:1 supervision throughout meals, as the resident allows. Recertification by the speech therapist on 4/8/21 revealed the resident□s liquids were upgraded to nectar thick on 3/26/21. Resident #10 continues to be able to read the signage posted in his room to remind him to eat slowly and take small bites. He continues to clear his airway by a strong cough

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F 684	Continued From page 10 Review of Resident #10's medical record revealed no physician order for speech therapy, however there was a certification for speech therapy, which was the plan of care for therapy, and was dated for 02/26/2021 and 03/09/2021 signed by the Physician. Review of the speech recertification, progress report and updated therapy plan for certification dated 3-9-21 revealed objective and interpretation for swallowing requirements for Resident #10. Resident #10's results, that were signed by the speech therapist, were he exhibited difficulty with oral containment/secretion management 76-90% of the time. Documentation also revealed Resident #10 required supervision/assistance at mealtime 26-49% of the time for swallow safety. A review of March 2021 Physician order revealed Resident #10 was ordered a Regular Puree diet with Honey Thick Liquids. Review of an undated care card (used by the direct care worker) for Resident #10, identified the resident ate in his room and had received a puree diet. The eating skills section on the care card was blank and did not identify if resident was to be supervised, or if he had swallowing difficulties or what level of assistance Resident #10 required with eating. Observation on 3/22/2021 at 01:04 PM revealed Resident #10 was feeding himself lunch that consisted of Salisbury steak, mashed potatoes, stewed tomatoes, brownie, and a biscuit, along with honey thickened liquids, with all foods being pureed. There were no staff present in room. Resident was observed with food on chest and coughing. A sign was observed posted on Resident #10's wall in his view, by the speech	F 684	reflex. He frequently will not allow staff to sit with him while eating due to self-preservation and independence. Resident #10 was observed during each meal, as he would allow, until 4/23/21 when the speech therapist re-evaluated the resident and documented he was safe to eat independently. Resident #10 was discharged from speech therapy services on 4/23/21. At completion of speech therapy services, the resident□s diet remained pureed with nectar thick liquids. He was assessed as safe to eat independently. 2. Residents with thickened liquids are at risk. Review of the medical records of those 6 residents, completed on 3/26/21 by the Unit Coordinator and observations made during meal on 3/26/21, indicated no other residents were in danger of choking while eating. All residents observed were either safe to eat independently or were previously fed by staff. The review was completed on 3/26/21. Any resident admitted with orders for a thickened liquid will be screened by speech therapy and treated as the therapist deems necessary and the physician orders. Any resident requiring assistance and/or observation during meals, as a result of the therapy evaluation, will have a staff member assigned to assist during each meal. 3. Nursing staff were educated on compensatory methods to use with residents that displayed swallowing issues to include sitting upright during meals, not	

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F 684	Continued From page 11 therapist with safe swallow tips that included 1. small bites and sips, 2. eat slowly, 3. sit upright and 4. make sure your mouth is clear before each bite. He was sitting upright, however was not performing the tasks on the sign during the observation. On 3/22/2021 at 1:30 pm Nurse #1 was informed by the surveyor that Resident #10 was coughing while he was eating his lunch meal. Nurse #1 stated it was normal for the resident to cough while he ate. She stated she monitored the resident for aspiration after meals and speech worked with the resident, and usually was in the room when the resident was eating. She stated the resident was able to feed himself. An observation was conducted on 3/24/2021 at 8:55 am of the breakfast meal, which consisted of eggs, sausage, toast, and hot cereal (oatmeal), with all items of puree consistency. Resident #10 was observed to be sitting upright in bed feeding himself and there were no staff present. He was Oatmeal was observed on Resident #10's chest, he was coughing and having difficulty breathing. Resident #10 was observed to cough up a large amount of food, and expelled oatmeal and mucous from his nasal passages. Attempted to locate staff immediately due to not being able to reach the call light, to assist Resident #10 and was unable to locate a staff member who was assigned to care for Resident #10. A nursing assistant (NA #1), from another unit came to assist Resident #10. NA #1 was observed on 3-24-21 at 8:57am to enter Resident #10's room and was observed to clean the residents' nose and stayed with the resident until NA #3 arrived in the room.	F 684	using straws (if indicated by the speech therapist), eating slowly, eating small bites and alternating food and fluid. Education also included observing for signs and symptoms of potential aspiration including sneezing during meals, gurgling sounds at the back of the throat, runny nose, increased temperature. Unlicensed staff were educated to inform their nurse if residents were observed displaying signs and symptoms of aspiration. Nurses were educated to notify the residents physician for any signs or symptoms of aspiration. Care plans will be revised by the coordinators, DON or the MDS nurse as needed to reflect the care each resident requires related to aspiration precautions, assistance needed and thickened liquids. Education started on 3/24/21 for nursing staff and was completed on 3/26/21. Education was conducted by the Regional Nurse Consultant, Unit Coordinator, and the Director of Nursing. The Staff Development Coordinator will include training to all new nurses and nursing assistants. Audits will be held of those residents receiving thickened liquids by the Resident Care Coordinators, Unit Coordinators and/or the Director of Nursing 3 times per week x 2 weeks, 1 x week x 4 weeks to assure each resident receives the care planned interventions. Audits will continue until substantial compliance is achieved and maintained. Audits started on 3/26/21. 4. Results of the audits will be presented to the Quality Assurance/Performance	

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F 684	Continued From page 12 On 3/24/21 at 8:59 am NA #3 entered Resident #10's room and relieved NA #1. NA #3 stated the resident coughed sometimes when eating and sometimes he was fed by therapy. She stated she was informed by therapy to sit him up straight and he could feed himself. On 3/24/2021 at 9:00 am NA #4 entered Resident #10's room and stated she would call the Nursing supervisor due to resident observation by the surveyor. On 3/24/2021 at 9:01 am NA #3 assisted Resident #10 with the remainder of his breakfast meal. The resident continued to cough but not to the degree of the episode observed earlier, the resident as stated below refused to continue to eat, he was still in an upright position. On 3/24/21 at 9:03 am Nurse #2, from another hall, entered Resident #10's room and stated she was asked to come check on the resident. When she entered the room, the bed was in an upright position, but she raised the head of bed more and stated she would get speech therapist (ST) to come and check on Resident #10. On 3/24/21 at 9:07 am an observation was made of Resident #10 continuing to cough, and thick mucus continued to expel from the resident's nasal passages, Nurse #2 and NA #3 were with the resident at this time. An interview was conducted on 3/24/21 at 9:10 am with the ST in Resident #10's room. The ST stated the resident could feed himself independently and the coughing was normal, and it was his baseline. The ST stated Resident #10	F 684	Improvement Committee by the DON.	

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had poor awareness, his ability to open his mouth was limited and caused him to have difficulty controlling his food bite size. Additionally, she stated his cough was productive and that was ok. She stated a fiberoptic endoscopic evaluation of swallowing (FEEs) test would be scheduled to determine if he could be upgraded from a honey consistency thickened liquid. She discussed the resident was tolerating his puree diet well and she believed the excess of mucous was from the honey thick liquids. She stated she currently was working with Resident #10 three times a week. ST therapist further stated she had informed staff resident could eat independently and he was able to read and follow the instructions on the sign. She did not address the care plan that stated he needed to be supervised during meals.

On 3/24/21 at 11:19 am an interview was conducted with NA #2. She stated she was taking care of Resident # 10 today. She stated this was her first time working in the facility and first time working with the resident. Continued interview with NA #2 she stated she was given report today by another NA (she could not recall which NA) and was informed Resident # 10 was non-verbal, however could nod yes/no, required total care with ADL's and needed to be fed. NA #2 stated she was informed he needed to sit up when eating. She also stated she did not take his meal tray into his room and therefore didn't feed him. on that morning and was unaware of a sign with swallowing tips on his wall. She further stated she could not recall the NA that took the tray in the room or who told her in report he needed to be fed.

On 3/24/2021 at 11:32 am an interview was conducted with the MDS Coordinator and she

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stated Resident #10's quarterly MDS dated 1/4/2021 was coded as Resident #10 was unable to complete the brief interview mental status (BIMS). The MDS coded Resident #10 as needing supervision; oversight, encouragement with 1-person physical assist with eating. She stated the coding reflected the Nurse Aide documentation and had not been updated to reflect the ST documentation/recommendations. She stated the care plan was to be followed by the Nursing staff for the residents' plan of care but did not state when it should have been updated to reflect the ST recommendations.

On 3/24/20211at 11:40 am an interview was conducted with Nurse #3 and she stated Resident # 10 fed himself and he would not allow staff to feed him. She stated ST had setup a FEEs test, and Resident #10 did not need to be supervised during meals.

On 3/24/2021 at 11:51 am a follow-up interview was conducted with ST and Rehab Director. The ST stated the treatment plan of care dated 3/9/21 was not her recommendation but was the plan she followed when she was working with Resident #10. She further stated she wanted to be there for Resident #10's meals to give him cues and stated he was at an increased risk for aspiration, even with someone supervising him. She recommended resident feed himself for his quality of life. She reiterated she was working with Resident #10 three times a week and as a professional she could see the decline in the resident versus what the NA's saw. She stated she had not formally trained staff on Resident #10 swallowing tips, but the signage was posted for the resident and staff. She stated Resident #10 could look at the signage even if he could not

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read it and he knew that he was supposed to follow the swallowing tips. She stated she had been working with Resident #10 and he could understand by giving a thumbs up. She had no explanation of why she had not trained staff. She stated resident could aspirate even if someone was in the room at the time.
An interview with the Administrator occurred on 3/24/2021 at 10:15 am. The Administrator stated she had spoken with ST after the episode on 3/24/2021 about her recommendations and she was informed Resident #10 could feed himself. Additionally, she stated she had approved the FEEs test.

On 3/24/21 at 5:36 pm an interview was conducted with the Physician for Resident # 10 and he stated the plan of care was usually for staff to know how to care for the resident. He stated he would think staff would follow the care plan directions/instructions to care for Resident #10. He stated ideally someone should have been with Resident #10 during the mealtime.

The Administrator was notified of Immediate Jeopardy on 3/25/21 at 4:32 pm.
On 3/26/21 the facility provided the following credible allegation for Immediate Jeopardy removal:

1. Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance

" Residents at risk of suffering a serious adverse outcome include six (6) residents, including the named resident, receiving either honey thick liquid or nectar thick liquid. The care plans and care cards of all residents were

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reviewed on 3/25/21 by the Regional Nurse Consultant. Only 2 of the 6 were care planned as requiring supervision during meals. This is achieved due to the residents' dependence upon staff to physically assist with meal intake. One of the 6 residents receive pleasure feeding and is assisted by staff during this activity. Three of the 6, including the named resident (see the 2/25/21 plan of care, developed by the speech therapist) were identified as independent with eating. Resident #10 or any resident receiving a mechanically altered diet and thickened liquids are always at risk for coughing, choking and/or aspiration pneumonia. Resident #10 has resided in the community since 6/4/20. He has had 1 hospitalization that was totally unrelated to any issues that would be secondary to any swallowing difficulties.

" Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.

Resident #10's physician ordered an X-ray to assess for potential aspiration. This will be completed by 3/26/21. Results of the X-ray were returned on 3/26/21 indicated Resident #10 had no signs of aspiration pneumonia. Vital signs were increased to every 4 hours for the named resident x 24 hours, to include auscultation of lung sounds and oxygen saturation. These measurements will be recorded on the resident's medication administration record and/or in the resident's electronic medical record. The speech therapist will continue to treat per the results of her evaluation and plan of care that was previously established. The plan of care based on the therapist's evaluation included Resident

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#10 actively participating in answering prompts for yes/no questions with 75% accuracy, creating a low-tech communication board for wants and needs and increasing his functional communication skills. With the speech therapist the resident's diet will be upgraded and a development of a maintenance program. The therapist documented Resident #10 demonstrated good rehabilitation potential as evidenced by his motivation for participation in therapy sessions. The Speech Therapist would continue with the plans to perform a Fiberoptic Evaluation of Swallowing (FEES) for Resident #10 (a FEES is used to determine if a person had swallowing difficulties). The FEES was approved on 3/24/21, but the community has a scheduled date of 3/26/21. The resident's physician assessed the resident on 3/25/21 and found the resident to be without signs and symptoms of aspiration or any ill-effects from the alleged choking episode (as described by the surveyor). The physician also reviewed the evaluation and plan of care for the resident, developed by the speech therapist, on 3/25/21 and agreed with the therapist's recommendations and plan of care that indicated the resident was safe to eat independently. The resident's care plan and care card were reviewed and revised by the Regional Nurse Consultant, on 3/25/21, to reflect the named resident would receive 1:1 supervision throughout meals, as the resident allows. Resident #10 will continue to feed himself. Staff will sit in the room to provide supervision such as cueing the resident to refer to the guidelines posted on the wall by the Speech Therapist. The guidelines include to eat slowly, take small bites of food and small sips of water. The resident, who is alert and able to communicate his preferences by nods and gestures, at times

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refuses to allow staff to give cues. Resident #10 becomes angry and refuses to eat if he feels staff are invading his space and remains in his room.

Education was started on 3/25/21 for all licensed staff and unlicensed staff. Education provided by the Regional Nurse Consultant and the Unit Manager included providing 1:1 supervision throughout meals as the resident would allow and to leave the room if the resident requested and report this to the nurse. The nurses were educated to document all refusals of staff assistance by the residents. Licensed and unlicensed nursing staff were also educated on reminding the resident of the instructions, given by the speech therapist. These instructions include but are not limited to take small bites of food and sips of water, sit upright in bed during meals and eat slowly. The resident acknowledges by nods that he is able to read the instructions on his wall, instructions are posted at eye level so when Resident #10 is sitting upright to eat he can easily read the instructions and acknowledges by nods that is understands the instructions. Staff were educated that coughing is a baseline for Resident #10 and does not waiver from his baseline as indicated in the speech therapy evaluation and daily notes. Education for both licensed and unlicensed staff included coughing as a safe practice for Resident #10 and any resident that swallows incorrectly as a safe and preferred practice to clear his throat and keep his airway unobstructed. Resident #10's baseline also includes expelling food as a normal process, identified by the speech therapist, because of the named resident's small oral opening and trying to insert the spoon while eating with his tongue thrusting outward. Education for licensed and unlicensed staff

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included observing for signs and symptoms of aspiration for all at risk residents of choking. Those signs and symptoms of choking and or aspiration include, but are not limited to, coughing, eyes tearing, wet sounding gurgles, increased temperature, abnormal lung sounds and runny nose. Education also included and will continue to include interventions to decrease the risk of aspiration including providing the pureed diet, thickened liquids, sitting the resident straight up in bed, cueing him, as he will allow, to eat slowly and take small sips of fluids and small bites of food. Licensed staff were educated and will continue to be educated should the residents' at risk of choking or aspiration temperature rise to a rate of 100.4, they notice a change in oral discharge, the residents become lethargic to notify the residents' physician for further direction in their care. This education began on 3/25/21 and was provided by the Regional Nurse Consultant and the Unit Coordinator.

Education began on 3/25/21 and was provided by the Regional Nurse Consultant and the Unit Coordinator. All education referenced was initiated on 3/25/21 by the Regional Nurse Consultant and the Unit Coordinator and was provided to licensed and unlicensed nursing staff. Education will be completed on 3/26/21.

Licensed and unlicensed nursing staff not receiving education prior to 3/26/21, will not be allowed to work until education has been completed.

Effective 3/25/21, this education will be included in general orientation for new licensed and unlicensed nursing staff.

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With all new referrals to speech therapy, the therapists will review the chart to determine reason for referral, prior treatment, medical history, any noted behaviors including non-compliance. The speech therapist then evaluates the resident during a meal and or snacks. Conversation is held with staff familiar with the referred resident to determine what is "normal" for the resident.

During treatment from the speech therapist, staff receive information through verbal communication to the interdisciplinary team during morning clinical meeting. The Director of Nursing and/or the Unit Coordinator then revises the residents' care guides and care plan to reflect the current condition of the individual resident.

Licensed Nursing or Department Head will monitor meal supervision, utilizing a "Dining Supervision Manager Observation" sheet. Supervision is being provided to ensure aspiration and safety precautions are being followed during meals in the dining rooms (as applicable) and for residents that eat in their rooms. Staff mentioned above will be assigned to each meal for supervision utilizing the assignment calendar. The Director of Nursing will assign managers to the dining rooms to include resident rooms.

The 6 residents identified as "at risk" will be assessed if any signs and symptoms of choking and/or aspiration are reported to the licensed nursing staff. Referrals will be made to the speech therapist for any resident exhibiting any signs or symptoms of chocking and / or aspiration.

The facility alleges the removal of the immediate

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F 684	Continued From page 21 jeopardy on 3/26/2021. The Administrator is responsible for assuring corrective actions are sustained. On 3/26/2021 at 4:00 pm the facility's credible allegation for Immediate Jeopardy removal, with an Immediate removal date of 3/26/2021 was validated as evidenced by observations of a sample of residents identified as having swallowing difficulties, licensed and un-licensed staff interviews, facility training that included providing 1:1 supervision throughout meals as the resident would allow. Licensed and unlicensed nursing staff were also educated on reminding the resident of the instructions, given by the speech therapist. Additionally, education for licensed and unlicensed staff included observing for signs and symptoms of aspiration for all residents at risk of choking. Education also included and will continue to include interventions to decrease the risk of aspiration, and should the residents' at risk of choking or aspiration temperature rise to a rate of 100.4, they notice a change in oral discharge, the residents become lethargic to notify the residents' physician for further direction in their care.	F 684		
F 693 SS=E	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to	F 693		5/4/21

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F 693	Continued From page 22 eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview the facility failed to administer the tube feeding formula as ordered by the physician. This was evident for 1 of 2 residents reviewed for tube feeding (Resident #12). Findings Included: Resident #12 was admitted to the facility 2/14/20 and diagnoses included traumatic brain injury and use of gastrostomy tube (a surgically placed tube into the stomach). An annual minimum data set (MDS) dated 1/5/21 for Resident #12 identified he had a feeding tube that provided 51% or greater of his total daily calories and 501 cubic centimeters (cc) or greater of his total daily fluid intake. He was totally dependent on staff for eating and his cognition was severely impaired. A progress note written by the Registered Dietitian (RD) dated 2/3/21 for Resident #12 stated in part, no significant weight changes for	F 693	F693 The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. 1. The facility failed to administer the tube feeding formula as ordered by the physician for Resident #12. An order was obtained and entered for Nutren 2.0 versus the Nutren 1.5 that was administered. Resident #12□s tube feeding pump was recalibrated to reflect the amended orders on 3/24/21 by the Unit Manager. 2. All residents receiving tube feedings are at risk. An audit was completed on 3/24/21 by the Central Supply clerk for those receiving tube feeding. Each resident□s tube feeding was verified with the physician□s order to assure	

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F 693	Continued From page 23 30 or 90 days. Diet order for pleasure feedings of pureed foods and nectar thickened liquids. Oral intake 0 to 100% per staff. The resident is also tube fed with nocturnal feedings of a name brand formula with 2.0 calories per ml at 75 ml per hour from 8:00 pm to 8:00 am with a 200 ml water flush every 4 hours. This provided approximately 1800 calories, 76 grams of protein and 1823 ml of fluids daily. Calculated nutritional needs provided. Review of the March 2021 physician orders for Resident #12 identified an order for a name brand feeding formula that provided 2.0 calories per ml at 75 ml/hour from 8:00 pm to 8:00 am. The order was dated 1/31/21. The resident also had an order for pleasure feeding tray of puree foods, yogurt, ice cream, pudding and applesauce with nectar thick liquids that was dated 1/27/21. An observation of Resident #12 on 3/22/21 at 12:16 pm revealed a ready to hang container of a name brand feeding formula that provided 1.5 calories per milliliter (ml) was connected to a feeding pump. The feeding pump was off, and the container of feeding formula was dated 3/21/21; run at 75 ml/hour from 8:00 pm to 8:00 am. An observation of Resident #12 on 3/24/21 at 12:00 pm revealed a ready to hang container of a name brand feeding formula that provided 1.5 calories per ml was connected to a feeding pump. The feeding pump was off, and the container of feeding formula was dated 3/23/21; run at 75 ml/hour from 8:00 pm to 8:00 am. Review of the medication administration record (MAR) for Resident #12 identified an order for a name brand feeding formula that provided 2.0 calories per ml at 75 ml/hour from 8:00 pm to	F 693	administered formula matches the order. There were no other discrepancies found. 3. The Staff Development Coordinator (SDC) or Unit Coordinators (UC) will educate licensed nurses to match the order with the tube feeding prior to administering the feedings. This education was started on 4/23/21 and will be completed by 4/29/21. The education will be presented during orientation to each licensed nurse. The central supply clerk was educated on 3/24/21, by the Administrator; to also check the order when supplying the tube feeding formula to the residents□ care area. The UC or Resident Care Coordinators (RCC) will audit orders for new residents with feeding tubes to ensure there is an order in place and the correct tube feeding formula is ordered and administered at the correct rate. The UC or RCC will audit each tube fed resident on their units 3 x a week x 4 weeks, twice weekly x 4 weeks and then weekly x 4 weeks to assure each tube fed resident is receiving the correct formula at the correct rate or until substantial compliance is achieved and maintained. The audits began on 3/24/21. 4. The results of the tube feeding audits will be presented to the Quality Improvement/Performance Improvement Committee by the UC for the designated units.	

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F 693	Continued From page 24	F 693		

8:00 am. The feeding was signed of as being administered on 3/21/21 by Nurse #4 and on 3/23/21 by Nurse #5.

An interview with the Registered Dietitian (RD) on 3/24/21 at 12:15 pm revealed Resident #12 was receiving a name brand feeding formula that provided 2.0 calories per ml at 75 ml/hour from 8:00 pm to 8:00 am. She stated when she calculated how many calories the resident received from the tube feeding, she did this based on him receiving a 2.0 calorie per ml formula. The RD stated she had not observed the feeding formula that was connected to his feeding pump; she just assumed he was receiving what the physician had ordered. She stated the resident ' s nutritional status was stable at this time.

An interview on 3/23/21 at 12:40 pm with the Central Supply Clerk revealed the nursing staff would provide her with the physician ' s orders for tube feeding formulas so she would know what to order. She stated the order she had for Resident #12 was a name brand feeding formula that provided 1.5 calories per ml. The Central Supply Clerk added she didn ' t know the residents order was for a name brand feeding formula that provided 2.0 calories per ml and she didn ' t believe there was any of that formula in the facility.

Multiple attempts were made to interview Nurse #4 by phone, but no return calls were received.

A phone interview on 3/30/21 at 9:30 am with Nurse #5 revealed she was the nurse for Resident #12 on 3/23/21. She stated she did not recall what feeding formula she had hung on

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F 693	Continued From page 25 3/23/21, but she assumed she hung what formula was identified on the MAR. A phone interview on 3/30/21 at 10:27 am with the acting Director of Nursing (DON) revealed she expected the nurses would administer the tube feeding formula the physician had ordered. A phone interview on 3/30/21 at 11:30 am with the Administrator revealed she expected the physician ' s orders to be followed.	F 693		
F 812 SS=E	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 interview the facility failed to ensure dishware was dry before stacked and ready for use. The facility additionally	F 812	F812 The creation and submission of this Plan of Correction does not constitute an	5/4/21

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F 812	Continued From page 26 failed to discard a case of expired supplement fortified nutritional shakes. This was evident in 1 of 1 kitchen observation. Findings Included: An observation of the kitchen on 3/22/21 at 10:35 am was conducted with the Dietary Manager (DM) and revealed the following: 1. The following dishware items stored at the steamtable ready for lunch service were noted to be stacked together wet: a. 9 of 9 plastic divided plates b. 22 of 22 plastic plate bases c. 10 of 10 plastic meal trays The DM stated the staff should have allowed all these items to air dry before they brought them to the steam table for service. She explained there were two storage racks for the divided plates and plate bases to air dry and the meal trays were typically kept in the dishrack on the clean end of the dish machine to dry before they were stacked together. The DM added the staff got in a rush and did not allow the items to dry. 2. A partial case of chocolate supplement shakes were stored in the walk-in cooler with a date of 2/12/21 on the outside of the box. The DM explained the date of 2/12/21 on the supplement shakes was the date the shakes were placed in the cooler to thaw. The DM added she believed the supplement shakes were good to use up to 3 months after the thaw date. A follow-up interview with the DM on 3/24/21 at 11:45 am revealed she had checked on the	F 812	admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. 1. The wet dishware was taken out of service on 3/22/21 prior to the lunch service for the residents. The shakes with a thaw date of 2/12/21 were discarded on 3/22/21. No residents received the outdated shakes. On 3/23/21, the Dietary Manager (DM) audited the walk in cooler. No other outdated food items were found. 2. All residents have the potential to receive their meals from wet dishware and have the potential to receive outdated shakes. The DM was educated by the Administrator on 3/23/21 who in turn educated the dietary staff. Education included making sure all dishware was air dried prior to putting the dishware into a meal service. Additionally, education included assuring all nutritional supplements were to be used within 14 days of thaw date. If not used within the 14 days of thaw date, the nutritional supplements were to be discarded. 3. The DM, assistant DM or an appointed dietary employee will audit all stacked dishes to ensure wet nesting does not occur. Audits will also include observing the date of all thawed nutritional supplements to assure each supplement is used within 14 days of thaw or discarding. This will occur 5 times per week x 4 weeks, 3 times per week x 4 weeks and then weekly x 4 weeks or until substantial compliance is achieved and	

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F 812	Continued From page 27 storage dates for the supplement shakes and had determined they were only good to use for 14 days after the thaw date. She stated the shakes dated 2/12/21 were out of date and should have been thrown away by the 14th day. A phone interview on 3/30/21 at 11:30 am with the Administrator revealed she expected the dishes and service ware to be dried properly before being used. She added she also expected foods would be used or discarded by the use-by date.	F 812	sustained. 4. The results of the audits will be presented to the Quality Assurance/Performance Improvement Committee for 3 months by the DM or the Assistant DM. The QAPI committee will determine the need for further auditing after the initial 3 months.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and	F 880		5/4/21

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procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§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

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F 880	Continued From page 29 IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview and physician interview, the facility failed to implement their infection control policies and procedures for personal protective equipment (PPE) and hand hygiene when 1 of 2 staff members (Nursing Assistant #1) failed to don PPE prior to entering an enhanced droplet isolation room and failed to perform hand hygiene before exiting the room for 1 of 1 resident (Resident #352) observed for infection control practices. This failure occurred during the COVID19 pandemic. Findings included: A review of the facility's "COVID Response Guidelines" policy and procedure dated 2-12-21 revealed in part; staff caring for residents who are new admissions should wear a N95 mask or higher, eye protection, gloves and gown. The policy and procedure also documented staff should follow principles to reduce the risk of COVID19 transmission which included performing hand hygiene. An observation of hall 400 occurred on 3-24-21 at 4:50pm. Resident #352 was observed to have his call light on and on his door was an enhanced droplet isolation sign. Nursing assistant (NA #1) was observed answering the call light by entering Resident #352's room without donning a gown, gloves or eye protection. The NA exited the resident room with the resident's water glass, without performing hand hygiene. NA #1 proceeded down the hall to the nourishment room, punching in the code to the nourishment	F 880	1. On 3/24/21 Nursing Assistant (NA) #1 was immediately re-educated by the Administrator and the Regional Clinical Consultant on isolation signage, following the directions on the signage and hand hygiene. Education included the importance of following the directions on the enhanced droplet isolation signage to include wearing gowns, gloves and eye protection when entering a room of a resident on said precautions. NA #1 was educated that wearing the proper protective equipment (PPE) decreased the risk of spreading droplet-based pathogens. He was also educated on proper hand hygiene and the role that proper to include when to wash hands and the importance of hand hygiene in decreasing the risk of spreading pathogens. 2. All staff are at risk of disregarding infection prevention signage posted which increases the risk of spreading droplet-based pathogens to other residents. 3. Education was initiated immediately started on 3/24/21 to staff by the Administrator, Unit Coordinator (UC), Director of Nursing (DON), Staff Development Coordinator (SDC) and/or the Regional Clinical Consultant. Education included the importance of following the directions on the enhanced droplet isolation signage to include wearing gowns, gloves and eye protection when entering a room of a resident on said precautions. Additionally, staff were	

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F 880	Continued From page 30 room, scooping ice into Resident #352's glass and then returning to the resident's room without performing hand hygiene or donning a gown, gloves or eye protection. When NA #1 exited the resident's room he performed hand hygiene by using the hand sanitizer dispenser on the wall located in the hallway. During an interview with NA #1 on 3-24-21 at 4:55pm, the NA stated, "I was just running in there for just a minute so I didn't think I needed to put on the PPE." He also confirmed he had not performed hand hygiene prior to leaving the resident room to retrieve the resident's ice and he stated, "I just forgot." NA #1 said he had received training on infection control, PPE and hand hygiene but could not remember when he had received the training. The resident's physician was interviewed on 3-25-21 at 8:35am. The physician confirmed he was the physician for Resident #352 and that Resident #352 was on enhanced droplet isolation. He discussed expecting staff to follow infection control practices and wear the required PPE which included a gown, mask, gloves and eye protection when entering a resident's room who was on enhanced droplet isolation. An interview with the Administrator occurred on 3-25-21 at 9:19am. The Administrator discussed staff had received training on infection control, don/doffing PPE and hand hygiene. She stated she did not know why the NA would have entered an enhanced droplet isolation room without following proper policy and procedure.	F 880	educated that wearing the proper protective equipment (PPE) decreased the risk of spreading droplet-based pathogens. The YOU TUBE videos were utilized in staff training (Sparkling Surfaces - https://youtu.be/t7OH8ORrg; Clean Hands - https://youtu.be/xmYMUly7qiE) in addition to the lecture type education sessions. An educational in-service sheet was provided for staff signatures to denote attendance at one of the educational sessions. Education for all current staff including contractors will be completed on 4/26/21; no employee will be allowed to work until they have received this training. Root cause Analysis 4.Root cause analysis-NA #1 had been educated previously on the need to wear PPE in rooms displaying signage that indicated the resident was on enhanced droplet precautions. He had signed as understanding after his education on 3/24/21. NA #1 was issued a final warning on 3/24/21. In discussion with the Administrator and Regional Clinical Consultant on 3/24/21, he acknowledged he was aware he should follow directions listed on the signage, but had chosen not to follow the instructions, due to just going in the room for a minute and not providing resident care. The root cause was NA #1 chose not to follow enhanced droplet precautions, although, he was aware of the potential consequences. 5. On 3/24/21 random audits began with staff working with residents on enhanced	

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F 880	Continued From page 31	F 880	droplet precautions. Audits will include all shifts and weekends. The audits will be conducted by the Unit Coordinators, Staff Development Coordinator and/or the Director of Nursing. Audits will occur 5 times a week x 2 weeks, 3 times a week x 2 weeks and weekly x 4 weeks or until substantial compliance is achieved and maintained. Any staff member found not complying with the instructions on signage for Enhanced Droplet Precautions will receive disciplinary action up to and including termination. 6.Results of the audits will be presented Monthly to the Quality Assurance/Performance Improvement Committee by the Staff Development Coordinator.	