STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345229	A. BUILDING _____ B. WING _____	C 05/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - SHELBY	**1101 NORTH MORGAN STREET SHELBY, NC 28150**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Recertification survey was conducted on 05/02/2021 through 05/06/2021. Additional information was obtained offsite through 05/18/21. Therefore, the exit date was changed to 05/18/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # JXFK11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification survey, complaint investigation and onsite revisit were conducted on 05/02/21 through 05/06/21. Additional information was obtained offsite through 05/18/21. Therefore, the exit date was changed to 05/18/21. Tags F637, F640 and F580 were corrected as of 05/18/2021. A repeat tag was cited. New tags were also cited as a result of the recertification and complaint investigation survey that was conducted at the same time as the revisit. The facility is still out of compliance. There were 25 allegations investigated. 12 of the 25 allegations investigated were substantiated and cited. Immediate Jeopardy was identified at: CFR 483. 12 at tag F600 at a scope and severity (J) CFR 483. 25 at tag F689 at a scope and severity (J) The tags F600 and F689 constituted Substandard Quality of Care. Immediate Jeopardy for F 600 began on 05/05/2020 and ended on 05/0720/21.	F 000		

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

Electronically Signed | 06/01/2021

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F 000	Continued From page 1 Immediate Jeopardy for F 689 began on 03/13/2021 and ended on 05/07/2021. An extended survey was conducted on 05/14/21.	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. §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	F 550		6/7/21

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F 550	Continued From page 2 from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, resident, and staff interview's the facility failed to provide incontinence care for 3 of 3 residents sampled for incontinence (Resident #42, Resident #16 and Resident # 17). The residents expressed feelings of being upset, angry, embarrassed, unclean and uncomfortable. The findings included: 1. Resident #42 was admitted to the facility on 04/06/21 with diagnosis that included renal insufficiency and diabetes mellitus. Review of Resident #42's quarterly Minimum Data Set (MDS) dated 04/13/21 revealed she was cognitively intact for decision making. Resident #42 required extensive assistance of two staff members for bed mobility and transfers. She was coded as being dependent on one staff member for assistance with toileting. Resident #42 was coded as being always incontinent of bladder and frequently incontinent of bowel. Review of Resident #42's care plan dated 12/12/19 and updated on 02/12/21 revealed a focus area for urinary incontinence. The care plan stated Resident #42 was incontinent of bowel and bladder and required fluid restrictions due to	F 550	F550 Residents affected: Residents # 42, #16, and #17 suffered no physical adverse effects related to the staffs alleged deficient practice but did express some emotional distress. Resident #42 and Resident #16 remain at the facility with no residual adverse effects. Resident #17 was discharged from the facility. Other residents with the potential to be affected: All other incontinent residents in the facility have the potential to be affected. An audit was conducted on May 25, 2021 by the Director of Nursing by interview and/or direct observation to determine if any additional residents were affected by the alleged deficient practice. It was determined that no other residents were adversely affected by the alleged deficient practice. System Changes:	

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F 550	Continued From page 3 congestive heart failure and was at risk for urinary tract infections. Interventions included providing assistance to the bathroom, monitoring of fluid intake and frequent incontinence rounding. On 05/02/21 at 10:45 AM an interview was conducted with Resident #42. During the interview she stated on 04/25/21 she was provided incontinence care at 3:00 PM by the Nurse Aide. She stated the facility did not have a Nurse Aide (NA) on the hall from 7:00 PM to 11:00 PM on 04/25/21. The interview revealed she was not provided incontinence care again until 3:00 AM when a NA had come on duty and was completing her third shift incontinence rounding. Resident #42 stated she was upset feeling sad and embarrassed because she had to wait along with her roommate in a soiled brief to be changed. She stated when she was finally changed the NA had to change her brief along with her bed sheets because the urine had soaked through. The interview revealed she had filed a grievance with the facility regarding the issue. Review of a grievance dated 04/26/21 revealed on 04/25/21 Resident #16 stated the NA rounds were not performed as much as needed. Steps taken to investigate the incident included interviewing the resident, interviewing staff, review of the assignment schedule and interview with additional residents. The grievance stated the facility may need to improve time management versus caseload difficulty. Corrective action taken included an apology given to the resident. On 05/03/21 at 3:05 PM an interview was conducted with NA #1. She stated she was	F 550	The facility policies related to incontinence care were reviewed by facility administration and no updates were necessary. This was conducted on May 25, 2021. All nursing staff and any contracted nursing staff will be educated regarding resident□s rights/exercising of resident rights and timely incontinence care. This will be completed by the Staff Development Coordinator and/or designee by June 7, 2021. This education will include the following: " 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. " 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. " 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. " The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. " Problems associated with incontinence and moisture, including skin breakdown	

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F 550	Continued From page 4 working on 04/25/21 during the 7:00 PM to 7:00 AM shift. The interview revealed the facility only had two NAs for a total of 73 residents during the shift. NA #1 stated she had frequently come into work and residents hadn't been provided incontinence care. NA #1 stated she remembered having to do a complete bed change for Resident #42 and her roommate. She stated Resident #42 was soaked with urine through her brief onto her bed pad and bed sheets when she finally got into the room to change her. NA #1 stated she was unable to complete every 2-hour incontinence rounding due to staffing in the building. She stated she may have been able to complete two incontinence rounds during her 12-hour shift for 73 residents. The interview revealed Resident #42 was not upset with her when she went in to change her bed but acted thankful that she was finally getting out of the wet brief and sheets. She stated once she came on shift she was assisting residents on another hall to bed and completing rounding prior to going to the hall Resident #42 resided. On 05/04/21 at 2:59 PM an interview was conducted with Nurse #2. She stated she was working on 04/25/21 on the 7:00 PM to 7:00 AM shift. The interview revealed she had received several complaints from residents regarding incontinence care and had changed residents herself during the shift. Nurse #2 stated the problem was the facility only had two NAs from 7:00 PM to 11:00 PM then an additional NA came in at 11:00 PM. She stated there were two nurses in the building for the 7:00 PM to 7:00 AM shift that were assigned to two halls themselves. The interview revealed usually from 7:00 PM to 12:00 AM the nurses were on a medication cart and unable to assist the NAs provide incontinent	F 550	" Preventing skin breakdown by providing timely incontinence care " Incontinent residents will be checked for incontinence every 2 hours at a minimum to determine the need for incontinence care. Any nursing staff out on leave or PRN status will be educated prior to returning to their assignment by the Staff Development Coordinator/designee. Newly hired nursing staff and any contracted nursing staff will be educated during orientation by the Staff Development Coordinator/designee. Monitoring An audit tool was developed to monitor incontinent residents to ensure that timely incontinence care has been provided as necessary to maintain resident cleanliness and comfort, and to determine if residents rights regarding incontinence care were being followed. The audit was initiated on May 25, 2021. The Director of Nursing, Staff Development Coordinator and/or designee will audit 5 incontinent residents 2x/week x 2 weeks, then weekly x 2 weeks, then biweekly x 4 weeks, then monthly x 1 month. These audits will occur on random days and shifts, including weekends. The audit will include observations and interviews to ensure compliance. The need for further monitoring will be determined by the prior month of auditing.	

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rounding to the residents. The interview revealed Resident #42 had complained to her regarding not receiving timely incontinence care. She stated the NAs were unable to complete every 2-hour rounding because of staffing and the facility not having enough help.

On 05/04/21 at 3:44 PM an interview was conducted with NA #2. During the interview she stated she was working on 04/25/21 during the 7:00 PM to 7:00 AM shift along with NA #1. She stated they were responsible for 73 residents and were unable to complete every 2-hour incontinence rounding. The interview revealed she tried to provide incontinence care twice during her shift, once when she came on shift and the second time being at the end of her 12-hour shift. The interview revealed residents had complained to her about having to wait on incontinence care.

On 05/05/21 at 10:34 AM an interview was conducted with the Director of Nursing (DON). The DON stated Resident #42 had filed a grievance regarding incontinence care on 04/25/21. He stated he had interviewed staff involved and gave an apology to the residents for having to wait on incontinence care. The interview revealed he told the NAs they needed to be more attentive to the residents needs and reviewed the schedule to see where the NAs were overloaded. The DON stated he hadn't completed any audits to ensure staff were completing incontinence rounding on a every 2-hour basis for residents. The interview revealed he was trying to staff with agency staffing to assist with the problem.

On 05/06/21 at 6:00 PM an interview was conducted with the Administrator. During the

Quality Assurance and Improvement Plan

The Director of Nursing and/or Staff Development Coordinator will bring results to the Quality Assurance and Performance Improvement Committee for review and further recommendations.

Completion date June 7, 2021.

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interview she stated incontinence rounding should be completed on a every two-hour basis for residents. She stated she had brought in two agency companies providing staff to assist with the issue however agency staff were calling out when they were scheduled to work which made it difficult.

2. Resident #16 was admitted to the facility on 09/24/19 with diagnosis that included renal insufficiency.
Review of Resident #16's quarterly Minimum Data Set (MDS) dated 02/10/21 revealed she was cognitively intact for decision making. Resident #16 required extensive assistance of one staff member for transfers and toileting. Resident #16 was coded as being always incontinent of bladder and bowel.

Review of Resident #16's care plan dated 12/18/19 and updated on 03/12/21 revealed a focus area for urinary incontinence and assistance with activities of daily living (ADL). Interventions included providing assistance to the bathroom and frequent incontinence rounding.

On 05/02/21 at 10:49 AM an interview was conducted with Resident #16. During the interview she stated on 04/25/21 she was provided incontinence care at 3:00 PM by the Nurse Aide along with her roommate Resident #42. She stated the facility did not have a Nurse Aide (NA) on the hall from 7:00 PM to 11:00 PM on 04/25/21. The interview revealed she was not provided incontinence care until 3:00 AM when a NA had come on duty and was completing her third shift incontinence rounding. Resident #16 stated she was angry, feeling upset and depressed because she had to wait along with

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F 550	Continued From page 7	F 550		

her roommate in a soiled brief to be changed. She stated when she was finally changed the NA had to change her brief along with her bed sheets because the urine had soaked through.

On 05/03/21 at 3:05 PM an interview was conducted with NA #1. She stated she was working on 04/25/21 during the 7:00 PM to 7:00 AM shift. The interview revealed the facility only had two NAs for a total of 73 residents during the shift. NA #1 stated she had frequently come into work and residents hadn't been provided incontinence care. NA #1 stated she remembered having to do a complete bed change for Resident #16 and her roommate. She stated Resident #16 was soaked with urine through her brief onto her bed pad and bed sheets when she finally got into the room to change her. NA #1 stated she was unable to complete every 2-hour incontinence rounding due to staffing in the building. She stated she may have been able to complete two incontinence rounds during her 12-hour shift for 73 residents. She stated once she came on shift she was assisting residents on another hall to bed and completing rounding prior to going to the hall Resident #16 resided.

On 05/04/21 at 2:59 PM an interview was conducted with Nurse #2. She stated she was working on 04/25/21 on the 7:00 PM to 7:00 AM shift. The interview revealed she had received several complaints from residents regarding incontinence care and had changed residents herself during the shift. Nurse #2 stated the problem was the facility only had two NAs from 7:00 PM to 11:00 PM then an additional NA came in at 11:00 PM. She stated there were two nurses in the building for the 7:00 PM to 7:00 AM shift that were assigned to two halls themselves. The

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interview revealed usually from 7:00 PM to 12:00 AM the nurses were on a medication cart and unable to assist the NAs provide incontinent rounding to the residents. The interview revealed Resident #16 had complained to her along with her roommate Resident #42 regarding not receiving timely incontinence care. She stated the NAs were unable to complete every 2-hour rounding because of staffing and the facility not having enough help.

On 05/04/21 at 3:44 PM an interview was conducted with NA #2. During the interview she stated she was working on 04/25/21 during the 7:00 PM to 7:00 AM shift along with NA #1. She stated they were responsible for 73 residents and were unable to complete every 2-hour incontinence rounding. The interview revealed she tried to provide incontinence care twice during her shift, once when she came on shift and the second time being at the end of her 12-hour shift. The interview revealed residents had complained to her about having to wait extended periods of time on incontinence care.

On 05/05/21 at 10:34 AM an interview was conducted with the Director of Nursing (DON). The DON stated Resident #42 had filed a grievance regarding incontinence care for her and Resident #16 on 04/25/21. He stated he had interviewed staff involved and gave an apology to the residents for having to wait on incontinence care. The interview revealed he told the NAs they needed to be more attentive to the residents needs and reviewed the schedule to see where the NAs were overloaded. The DON stated he hadn't completed any audits to ensure staff were completing incontinence rounding on a every 2-hour basis for residents. The interview revealed

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he was trying to staff with agency staffing to assist with the problem.

On 05/06/21 at 6:00 PM an interview was conducted with the Administrator. During the interview she stated incontinence rounding should be completed on a every two-hour basis for residents. She stated she had brought in two agency companies providing staff to assist with the issue however agency staff were calling out when they were scheduled to work which made it difficult.

3. Resident #17 was admitted to the facility on 10/02/21 with diagnosis that included hypertension and heart failure.
Review of Resident #17's quarterly Minimum Data Set (MDS) dated 02/26/21 revealed he was cognitively intact for decision making. Resident #17 required extensive assistance of one staff member for dressing and toileting. Resident #17 was coded as being always incontinent of bowel and frequently incontinent or urine.

Review of Resident #17's care plan dated 10/02/20 and updated on 03/17/21 revealed a focus area for urinary incontinence and assistance with activities of daily living (ADL). Interventions included providing assistance to the bathroom and frequent incontinence rounding.

On 05/02/21 at 10:05 AM an interview was conducted with Resident #17. He stated on 04/25/21 he rang his call bell at 7:15 PM and told a nurse who's name he could not remember that he needed to be changed because he had a bowel movement in his brief. The nurse stated to him she would get a NA to assist him. The interview revealed he didn't get his brief changed

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until 11:10 PM when NA #1 and Nurse #2 came into the room to assist him. Resident #17 stated he had sat in feces for 4 hours at that point and the NA had to change his bed pad along with his brief. He stated NA #1 told him she hadn't gotten to him because she was on another hall and the facility was short staffed. Resident #17 said Nurse #2 stated to him that he wasn't the only resident who had complained that day about not receiving incontinence care. Resident #17 stated it made him feel embarrassed, uncomfortable, and unclean having to sit in feces.

On 05/03/21 at 3:05 PM an interview was conducted with NA #1. She stated she was working on 04/25/21 during the 7:00 PM to 7:00 AM shift. The interview revealed the facility only had two NAs for a total of 73 residents during the shift. NA #1 stated she had frequently come into work and residents hadn't been provided incontinence care. NA #1 stated she remembered Resident #17 complaining that he had to sit in feces. NA #1 stated she was unable to complete every 2-hour incontinence rounding due to staffing in the building. She stated she may have been able to complete two incontinence rounds during her 12-hour shift for 73 residents. She stated once she came on shift, she was assisting residents on another hall to bed and completing rounding prior to going to the hall Resident #17 resided.

On 05/04/21 at 2:59 PM an interview was conducted with Nurse #2. She stated she was working on 04/25/21 on the 7:00 PM to 7:00 AM shift. The interview revealed she had received several complaints from residents regarding incontinence care and had changed residents herself during the shift. Nurse #2 stated the

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problem was the facility only had two NAs from 7:00 PM to 11:00 PM then an additional NA came in at 11:00 PM. She stated there were two nurses in the building for the 7:00 PM to 7:00 AM shift that were assigned to two halls themselves. The interview revealed usually from 7:00 PM to 12:00 AM the nurses were on a medication cart and unable to assist the NAs provide incontinent rounding to the residents. The interview revealed Resident #17 had complained to her about having to sit in feces. The interview revealed she finished her medication pass and provided incontinence care to Resident #17. She stated when she changed his brief he was sitting in feces and had to change his bed pad because it was soaking through his brief. She stated the NAs were unable to complete every 2-hour rounding because of staffing and the facility not having enough help.

On 05/05/21 at 10:34 AM an interview was conducted with the Director of Nursing (DON). The DON stated he had a grievance regarding incontinence care on 04/25/21. He stated he had interviewed staff involved and gave an apology to the residents for having to wait on incontinence care. The interview revealed he told the NA's they needed to be more attentive to the residents needs and reviewed the schedule to see where the NAs were overloaded. The DON stated he hadn't completed any audits to ensure staff were completing incontinence rounding on a every 2-hour basis for residents. The interview revealed he was trying to staff with agency staffing to assist with the problem.

On 05/06/21 at 6:00 PM an interview was conducted with the Administrator. During the interview she stated incontinence rounding should be completed on a every two-hour basis for

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F 550	Continued From page 12 residents. She stated she had brought in two agency companies providing staff to assist with the issue however agency staff were calling out when they were scheduled to work which made it difficult.	F 550		
F 561 SS=E	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by:	F 561		6/7/21

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F 561	Continued From page 13 Based on observations, record reviews, staff and resident interviews, the facility failed to honor resident's preference for number of showers per week for 4 of 6 residents reviewed for choices (Residents #16, #21, #23, and #42). The findings included: 1. Resident #16 was admitted to the facility on 09/24/19 with diagnoses which included hypertension, and dementia. The quarterly Minimum Data Set (MDS) dated 02/10/21 revealed Resident #16 was cognitively intact for daily decision making and needed extensive assistance for bathing that required two staff assist. Review of the shower schedule revealed Resident #16 was scheduled for showers on Wednesdays and Sundays during 1st shift. Resident #16's shower schedule for April 2021 further revealed on 04/11/21, 04/21/21, and 04/25/21 was not documented for receiving a shower or bath. The schedule also included three other scheduled shower days 04/04/21, 04/07/21, and 04/18/21 the resident did not receive a shower but a partial bath instead. An interview was conducted with Resident #16 on 05/04/21 at 5:25 PM which revealed the resident did prefer a shower and had made the staff aware. Resident #16 further revealed staff have told her the days she missed her scheduled shower was due to not having enough staff and the resident stated it had happened several times. An interview conducted with Nurse Aide (NA) #8	F 561	F561 Residents affected: Residents #16, #21, #23 and #42 suffered no physical adverse effects related to the staffs alleged deficient practice. All residents remain at the facility. Residents #16, #21, #23, and #42 were interviewed by Lead C N A and validated by the Director of Nursing on May 25, 2021 to determine preferences for bathing/showering. These preferences were documented on the facility shower schedule at the nursing station. Other residents with the potential to be affected: All other residents in the facility have the potential to be affected. An audit was conducted from May 10 □ 24, 2021 by the Director of Nursing to determine if any other resident in the facility had a preference for bathing/showering and to determine if these preferences were on the shower schedule and to determine if the bathing preference was honored as verbalized by the resident. It was determined that two other residents were affected by the alleged deficient practice. The identified residents□ preferences for bathing/showering were added to the shower schedule by Lead C N A on May 25, 2021. These residents stated that they did not suffer any adverse effects from the alleged deficient practice. System changes:	

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F 561	Continued From page 14 on 05/05/21 at 8:09 AM revealed Resident #16 preferred showers and had missed showers due to short staffing. The NA further revealed it was expected for shower schedules to be followed promptly. An interview conducted with NA#11 on 05/04/21 at 7:30 PM revealed that Resident #16 preferred showers and never refused. NA #11 stated Resident #16 did not receive showers due to short staffing and she was often not able to get to all residents scheduled showers completed and further indicated it was an ongoing issue in the facility. An interview conducted with the Interim Director of Nursing (DON) on 05/06/21 at 4:45 PM revealed there had been an issue with showers due to not having enough staff and the facility was working to improve the issue. The DON further revealed it was expected residents receive their scheduled shower per their preference. An interview conducted with the Administrator on 05/06/21 at 5:40 PM revealed it was expected residents receive their showers on the scheduled day and an in-service needed to be completed for this issue. 2. Resident #21 was admitted to the facility on 06/04/19 with diagnoses which included heart failure and chronic obstructive pulmonary disease. The quarterly Minimum Data Set (MDS), dated 04/20/21 revealed Resident #21 was cognitively intact for daily decision making and was totally dependent for bathing that required one staff assist.	F 561	The Staff Development Coordinator will educate all nursing staff and contract nursing staff on the following: " The residents right for self-determination, including choosing activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; " The residents right to choose bathing preferences and schedules. " Bathing preferences will be obtained during the admission process by the licensed nurse and/or CNA; " Resident□s families will be questioned as to whether they are aware of any bathing preference for any resident who is unable to verbalize a preference. " Nursing staff will adhere to the resident□s preference for bathing preferences and schedule. " Staff must document if a resident refuses care or why a shower was not provided to a resident according to the resident preferences and/or schedule. This will be completed by Staff Development Coordinator and/or designee by June 7, 2021. Any staff, contract employee out on leave of absence or prn status will be educated prior to returning to their assignment by the Staff Development Coordinator/designee. Any newly hired nursing staff and/or contracted nursing staff will be educated during orientation by the Staff Development Coordinator/designee. Monitoring	

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F 561	Continued From page 15 Review of the shower schedule revealed Resident #21 was scheduled for showers on Tuesdays and Fridays during 1st shift. Resident #21's shower schedule for April further revealed three scheduled days 04/02/21, 04/06/21, and 04/27/21 the resident received either a bed bath or a partial bath instead of a preferred shower. An interview conducted with Resident #21 on 05/04/21 at 5:20 PM revealed the resident preferred a shower and had made the staff aware of this. Resident #21 further revealed staff had told her the days she did not receive a shower was due to not having enough staff. Resident #21 stated she does not like to receive partial baths which include just cleaning her rear and changing her brief on her scheduled shower days. An interview conducted with NA #8 on 05/05/21 at 8:09 AM revealed Resident #21 preferred showers and had missed showers due to short staffing. The NA further revealed it was expected for shower schedules to be followed promptly. An interview conducted with Nurse #9 on 05/06/21 at 10:30 AM revealed Resident #21 preferred showers and the resident had not received showers on scheduled days due to not having enough staff. Nurse #9 further revealed Resident #21 did not refuse assistance with activities of daily living and should have received her scheduled preference. An interview conducted with the Interim Director of Nursing (DON) on 05/06/21 at 4:45 PM revealed there had been an issue with showers due to not having enough staff and the facility was working to improve the issue. The DON	F 561	An audit tool was developed to monitor for compliance: The audit tool includes the following: " Does the resident have a preference for bathing? " Was the resident□s preference for bathing honored as verbalized. " If not, is it documented as to the reason, i.e. refused, deferred due to condition, resident unavailable. The audit was initiated on May 25, 2021 by the Staff Development Coordinator and Director of Nursing. Audits will be conducted by the Staff Development Coordinator and/or Director of Nursing/designee on 5 residents weekly x 4 weeks, then biweekly x 4 weeks, then monthly x 1 month. These audits will occur on random days and shifts, including weekends. The need for further monitoring will be determined by the prior month of auditing. Quality Assurance and Performance Improvement (QAPI): The Director of Nursing and/or Staff Development Coordinator will bring results to the QAPI Committee for review and further recommendations. Completion date June 7, 2021.	

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further revealed it was expected residents receive their scheduled shower per their preference.

An interview conducted with the Administrator on 05/06/21 at 5:40 PM revealed it was expected residents to receive their showers on the scheduled day and an in-service needed to be completed for this issue.

3. Resident #23 was admitted to the facility on 12/08/15 with diagnoses which included heart failure.
The quarterly Minimum Data Set (MDS), dated 02/15/21 revealed Resident #23 was cognitively intact for daily decision making and was totally dependent for bathing that required one staff assist.

Review of the shower schedule revealed Resident #23 was scheduled for showers on Mondays, Wednesdays, and Fridays during 2nd shift. Resident #23's shower schedule for April further revealed 12 of his 13 shower scheduled on 04/02/21, 04/05/21, 04/07/21, 04/09/21, 04/12/21, 04/14/21, 04/16/21, 04/19/21, 04/21/21, 04/23/21, 04/26/21, and 04/30/21 he received a bed bath or a partial bath instead of the residents preferred shower.

An interview conducted with Resident #23 on 05/04/21 at 5:26 PM revealed the resident preferred a shower but rarely got one. Resident #23 further revealed staff had told him that on the scheduled day he did not receive a shower it was because of not having enough staff to help with showers.

An interview was conducted with NA #8 on 05/05/21 at 8:09 AM revealed Resident #23

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preferred showers and had missed showers due to short staffing. The NA further revealed it was expected for shower schedules to be followed promptly.

An interview conducted with NA #10 on 05/04/21 at 6:05 PM revealed Resident #23 preferred showers and the resident had not received showers on scheduled days due to not having enough staff. NA #10 further revealed she would try to give Resident #23 a good bed bath but knew this was not what he preferred.

An interview conducted with the Interim Director of Nursing (DON) on 05/06/21 at 4:45 PM revealed there had been an issue with showers due to not having enough staff and the facility was working to improve the issue. The DON further revealed it was expected residents receive their scheduled shower per their preference.

An interview conducted with the Administrator on 05/06/21 at 5:40 PM revealed it was expected residents receive their showers on the scheduled day and an in-service needed to be completed for this issue.

4. Resident #42 was admitted to the facility on 04/06/21 with diagnoses which included heart failure, and diabetes.

The quarterly Minimum Data Set (MDS), dated 04/13/21 revealed Resident #42 was cognitively intact for daily decision making and was totally dependent for bathing that required one staff assist.

Review of the shower schedule revealed Resident #42 was scheduled for showers on

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Mondays, Thursdays, and Saturdays during 1st shift. Resident #42's shower schedule for April further revealed three scheduled days 04/15/21, 04/17/21, and 04/24/21 were not documented for receiving a shower or bath. The schedule also included three other scheduled shower days 04/01/21, 04/10/21, and 04/12/21 the resident did not receive a shower but a partial bath instead.

An interview conducted with Resident #42 on 05/04/21 at 5:40 PM revealed she preferred showers but had not received showers several times due to not having enough staff on shift. Resident #42 further revealed she had never refused a shower and preferred a shower every time.

An interview conducted with NA #8 on 05/05/21 at 8:09 AM revealed Resident #42 preferred showers and had missed showers due to short staffing. The NA further revealed it was expected for showers scheduled to be followed promptly.

An interview conducted with NA #11 on 05/04/21 at 7:30 PM revealed Resident #42 preferred showers and had never refused. NA #11 stated multiple residents were not receiving their scheduled showers due to short staffing.

An interview conducted with the Interim Director of Nursing (DON) on 05/06/21 at 4:45 PM revealed there had been an issue with showers due to not having enough staff and the facility was working to improve the issue. The DON further revealed it was expected residents receive their scheduled shower per their preference.

An interview conducted with the Administrator on 05/06/21 at 5:40 PM revealed it was expected

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F 561	Continued From page 19 residents receive their showers on the scheduled day and an in-service needed to be completed for this issue.	F 561		
F 563 SS=E	Right to Receive/Deny Visitors CFR(s): 483.10(f)(4)(ii)-(v) §483.10(f)(4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. (ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time; (iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time; (iv) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and (v) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation. This REQUIREMENT is not met as evidenced by: Based on record review, observation and	F 563	F563	6/7/21

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F 563	Continued From page 20 interviews with resident, family member and staff, the facility limited visitation to 20 minutes per visit without reasonable clinical and safety cause for 3 of 3 residents (Resident #40, Resident #58 and Resident #47) reviewed for visitation. The findings included: A review of the facility's visitation letter sent out to family members on 4/5/21 indicated that visits will be allowed for a maximum of 20 minutes per visit. During the entrance conference with the Administrator on 5/2/21 at 10:15 AM, she stated that the facility did not currently have COVID-19 positive cases and that the facility was not in an outbreak status for COVID-19. 1. Resident #40 was admitted to the facility on 12/2/20 with diagnoses that included diabetes. The Quarterly Minimum Data (MDS) assessment dated 4/9/21 indicated Resident #40 was moderately cognitively impaired. An observation was made on 5/2/21 at 1:40 PM of Resident #40 being visited by a family member in the front porch of the facility. On 5/2/21 at 1:45 PM, an interview with Resident #40's family member revealed he had to call the facility ahead of time to schedule his visit and that he was only allowed to visit with Resident #40 for 20 minutes. Resident #40's family member did not know why his visit was limited to just 20 minutes. An interview with Resident #40 on 5/4/21 at 11:24 AM revealed she did not have enough time to talk to her family member on 5/2/21 because they	F 563	Residents affected: Residents # 40, #58, and #47 suffered no physical adverse effects related to the staffs alleged deficient practice. All residents remain at the facility with no residual adverse effects. Other residents with the potential to be affected: All other residents in the facility have the potential to be affected. Visitation Log was reviewed by Receptionist and Administrator on May 26, 2021 for dates ranging from April 25, 2021 □ May 25, 2021. It was determined that one family member may have been affected but had no residual adverse effects. Family member was informed per phone call on May 12, 2021 by receptionist that visitation restriction was lifted. System Changes: Peak Visitation Guidelines were reviewed by facility administration on May 26, 2021. No changes to the guidelines were necessary. Beginning May 7, 2021, families were advised by the receptionist when they called that visitation restrictions had been lifted and appointments were recommended but not required for visitation. Alert/oriented residents with BIMS 12-15	

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F 563	Continued From page 21 only let him stay for 20 minutes. After 20 minutes, they asked him to leave the facility. Resident #40 could not understand why they limited visitation to just 20 minutes. Resident #40 stated her family member worked all week and Sundays were the only days he could visit her, but she wished they let him stay longer. An interview with the Receptionist on 5/6/21 at 2:22 PM revealed family members were sent a letter on 4/5/21 regarding visitation. In the last letter, it was specified that they could only stay for 20 minutes. The Receptionist stated visits were being limited to 20 minutes to control the number of people being screened in the front lobby prior to visitation. The family members were encouraged to call ahead of time and schedule their visit so they could make arrangements and get residents ready for the visit. The Receptionist also stated they usually let visitors stay over 20 minutes if the visit qualified under compassionate care visits or if the family member requested to stay longer. An interview with Nurse Aide (NA) #5 on 5/6/21 at 2:37 PM revealed she was responsible for overseeing visitation on the weekends. NA #5 screened visitors when they came to the facility, checked their temperature, and encouraged them to wash their hands or use hand sanitizer. She also monitored the time of the visitation and usually asked them to leave after 20 minutes had passed. NA #5 confirmed that she had told Resident #40's family member to leave after visiting for 20 minutes because she was following the facility's visitation policy that visitors were only allowed to stay for 20 minutes per visit. An interview with the Director of Nursing (DON)	F 563	(Brief Interview for Mental Status Calculator) reflecting resident is cognitively intact, were informed by Activity Director on May 26, 2021 that visitation restrictions had been lifted and 20-minute restriction removed. Letters were mailed out to all residents□ responsible parties on May 26, 2021 informing them that 20-minute restriction to visitation has been removed. Staff Development Coordinator started education on May 14, 2021 with all facility staff. This included education on residents right to receive/deny visitors under certain circumstances; informing all facility staff that visitation restriction has been removed and visitation is allowed per the Peak visitation guidelines. This will be completed by June 7, 2021. An audit tool was initiated on May 25, 2021 to observe that visitors were not being restricted from visiting resident. Audit Tool consists of the following: (1) Visitation was allowed with the resident? (2) Was the visit restricted by a time limit? (3) Are you allowed 7 days a week visitation without restrictions? Monitoring Activity Director or designee will audit visitation by interviewing alert/oriented	

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F 563	Continued From page 22 on 5/6/21 at 4:30 PM revealed that it was his personal opinion that family members should be allowed to visit for as long as they wanted and visits should not be limited to just 20 minutes but they were only following company policy. The DON stated he did not know why the facility was limiting visitation to just 20 minutes per visit. An interview with the Administrator on 5/6/21 at 5:40 PM revealed that visitation should not be limited to just 20 minutes per visit. The Administrator stated their current visitation policy came from corporate and that she did not make the decision about it, but staff should not come to visiting family members and make them leave after 20 minutes. 2. Resident # 58 was admitted to the facility on 8/22/2017 with diagnoses of Multiple Sclerosis (MS). A review of her annual Minimum Data Set (MDS) dated 4/2/2021 showed she was mildly cognitively impaired. Review of a letter mailed on 4/5/2021 by the facility to families of residents stated visitation would be allowed for a time limit of 20 minutes. An interview with Resident # 58's daughter on 5/4/21 at 11:54 AM revealed she was not allowed to visit her mother for more than 20 minutes one time a week. She stated visitation was based on information disclosed in a letter she had received from the facility in April. The daughter stated the facility staff "acted like they were doing me a favor by letting me have 20 minutes with her. It's like they are holding her hostage."	F 563	residents who receive visits and contacting responsible parties who have visited the facility. This audit will be conducted for visits on different shifts, including weekends. Audits will be completed on 5 visits weekly x 4 weeks, then 5 visits every 2 weeks x 4 weeks, then monthly x 1 month. The results of the audits will determine the need for further monitoring. Quality Assurance Performance Improvement The Activity Director or designee will bring results to the Quality Assurance and Performance Improvement Committee for review and further recommendations. Completion Date June 7, 2021.	

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An interview with the Receptionist on 5/6/21 at 2:22 PM indicated she scheduled and screened for visitations. Based on instructions listed in the facility letter sent to families on 4/5/21. She stated scheduling was encouraged to prevent a bottle-neck of visitors requiring screening in the front lobby. She further stated scheduling the visits helped staff know what time residents needed to be up and dressed for their visit. She verbalized that exceptions were made for compassionate care visits.

An interview with Nurse Aide (NA) #5 on 5/6/21 at 2:37 PM revealed she was responsible for overseeing visitation on the weekends. NA #5 screened visitors when they came to the facility, checked their temperature, and encouraged them to wash their hands or use hand sanitizer. She also monitored the time of the visitation and usually asked them to leave after 20 minutes had passed.

An interview with the Director of Nursing (DON) on 5/6/21 at 4:30 PM revealed his personal opinion that family members should be allowed to visit for as long as they wanted, and visits should not be limited to just 20 minutes. He stated the facility was following company policy. The DON stated he did not know why visitation was limited to just 20 minutes per visit.

An interview with the Administrator on 5/6/21 at 5:40 PM revealed that visitation should not be limited to just 20 minutes per visit. The Administrator stated their current visitation policy came from corporate and that she did not make the decision about it, but staff should not ask visiting family members to leave after 20 minutes.

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3. Resident #47 was admitted to the facility on 07/01/19 with diagnosis which included chronic obstructive pulmonary disease and type 2 diabetes.

Review of Resident #47 quarterly Minimum Data Set (MDS) dated 04/14/21 revealed Resident #47 was cognitively intact and was total dependent with majority of activities of daily living (ADL).

An interview conducted with Resident #47 on 05/03/21 at 3:20 PM revealed visitation occurs one time a week with her family for no more than twenty minutes. Resident #47 further revealed she has requested more visitation time and staff has denied the request.

An interview conducted with the Resident #47's legal representative on 05/03/21 at 6:30 PM revealed the facility allows one visit per week for twenty minutes. The legal representative further revealed the visits must be scheduled and wishes the facility would allow more time for visitation.

An interview was conducted with the Receptionist on 05/06/21 at 2:20 PM revealed a prior letter was sent out to residents' families that encouraged family members to schedule their visitation. The Receptionist further revealed visits were being limited to twenty minutes to reduce overflow of people in the facility, but she never denied family members extra time or compassionate care visits.

An interview conducted with the Director of Nursing (DON) on 05/06/21 at 4:30 PM revealed the visitation policy letters sent to residents and families stated visitation is one time per week for twenty minutes. The DON further revealed

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F 563	Continued From page 25 visitation between residents and family should not be controlled. An interview conducted with the Administrator on 05/06/21 at 5:40 PM revealed a letter was given to residents and family that stated visitation would be allowed one time a week for twenty minutes to reduce overflow of people in the facility. The administrator further revealed there should not be a limit of how long and how many visits per week residents can receive.	F 563		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, staff and physician interviews, the facility neglected to provide necessary care and services to a surgical wound. The resident was admitted into the hospital on 05/08/20 with a diagnosis of necrotizing fasciitis and sepsis undergoing emergent debridement of an abscess and necrotic tissue. This was for 1 of	F 600	F 600 Resident affected Resident #166 was transferred to the hospital on May 8, 2021 and did not return to the facility.	6/7/21

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F 600	Continued From page 26 3 sampled resident's reviewed for providing care according to professional standards (Resident #166). Immediate Jeopardy began on 05/05/20 when Nurse #1 failed to identify the need for and provide nursing and medical interventions when Resident #166 was noted to have a foul odor with a large amount of yellow drainage coming from her surgical wound. The immediate jeopardy was removed on 05/07/21 when the facility provided and implemented an acceptable credible allegation for Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity level of an "D" (No actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems put into place are effective. The findings included: Review of Resident #166's hospital discharge summary dated 4/21/20 revealed she would need her wound vac to her midline abdominal surgical incision changed three times a week on Monday, Wednesdays and Fridays. Vacuum-assisted (wound vac) closure of a wound is a type of therapy to help wounds heal. During the treatment, a device decreases air pressure on the wound. This can help the wound heal more quickly. The gases in the air around us put pressure on the surface of our bodies. A wound vacuum device removes this pressure over the area of the wound. This can help a wound heal in several ways. It can gently pull fluid from the wound over time. This can reduce swelling and may help clean the wound and remove bacteria. A wound	F 600	Other residents with potential to be affected An audit was completed by the Administrator, Staff Development Coordinator (SDC), Treatment Nurse and Director of Nursing on 5/06/2021 of all residents to check for the following items: Does the resident have a wound? Are appropriate treatment orders in place? Have the treatments been completed as ordered? Are there signs and symptoms of infection or worsening condition? Has the physician been notified of worsening condition? There were no additional residents identified as having been affected by the alleged deficient practice. System changes On 5/6/2021, the treatment nurse was educated by the Administrator on responsibilities to ensure that all wounds are assessed upon admission and that appropriate physician orders are in place for treatments for all wounds. All licensed nursing staff were educated by the Administrator, Corporate Nurse Manager, and/or the Staff Development Coordinator on the following: Implementation of treatment orders, management and care of wounds, signs and symptoms of wound complications, regular wound assessment, to report signs and symptoms of infection, including redness, increased drainage, foul smelling drainage, elevated temperatures, change	

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VAC also helps pull the edges of the wound together. And it may stimulate the growth of new tissue that helps the wound close.
A wound vacuum system has several parts. A foam or gauze dressing is put directly on the wound. An adhesive film covers and seals the dressing and wound. A drainage tube leads from under the adhesive film and connects to a portable vacuum pump. This pump removes air pressure over the wound. It may do this either constantly or it may do it in cycles.

The dressing is changed every 24 to 72 hours.

A wound vacuum system may help your wound heal more quickly by:
- Draining excess fluid from the wound
- Reducing swelling
- Reducing bacteria in the wound
- Keeping your wound moist and warm
- Helping draw together wound edges
- Increasing blood flow to your wound
- Decreasing redness and swelling

Resident #166 was admitted into the facility on 4/21/20 following a hospital admission where she underwent an exploratory laparotomy and right colectomy for an incarcerated incisional hernia with perforated cecum. Admitting diagnosis included hernia, peritonitis, and hypertension.

Review of Resident #166's Skin Integrity Review dated 4/21/20 revealed she had a 6-inch surgical site to her midline abdomen which was packed with gauze.

Review of Resident #166's April 2020 Physician orders revealed an order initiated on 04/21/20 which read, "Apply wound vac to residents'

in mental status, decline in status and resident refusals of care to the MD/NP and resident representative immediately. This was completed on 5/7/201.

All CNAs were educated by the Administrator, Staff Development Coordinator, Treatment Nurse and/or DON on monitoring residents for declines and changes in conditions and how to respond to resident refusals and to report signs and symptoms of infection, including redness, increased drainage, foul smelling drainage, elevated temperatures, change in mental status and decline in status and to report these findings to the nurse immediately. This was completed on 05/07/2021.

Any licensed nurse or Certified Nursing Assistant out on leave or on PRN status will be educated prior to returning to duty by the Director of Nursing, Staff Development Coordinator, and/or the Treatment Nurse. Any newly hired licensed nurse and CNA will be educated during orientation by the Staff Development Coordinator.

Monitoring

The Treatment Nurse will review all new admissions daily to ensure that any resident wounds have appropriate physician orders for treatments. Treatment nurse will also review the Facility Activity Report in the electronic health record daily to see if any new wounds have been identified by nursing

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F 600	Continued From page 28 surgical site (mid abdomen) as soon as she arrived in the facility". The review revealed the order was signed off by Nurse #1. The order did not include how often to change the wound vac. Review of Resident #166's Treatment Administration Record (TAR) for April 2020 revealed a wound vac was initialed by Nurse #14 as being applied on 04/21/20. The review revealed no orders to change the residents wound vac for April 2020. On 05/04/21 at 9:15 AM and 11:35 AM voicemails were left for Nurse #14 with no return phone call. On 05/06/21 at 5:40 PM a third voicemail was left for Nurse #14 with no return phone call. Review of Resident #166's Physician orders dated 04/23/20 revealed an order which read, "monitor wound vac every shift to mid abdomen to make sure it's functioning properly". The order was initialed as completed by the nurses for each shift from 4/23/20 through 05/08/20. The admission Minimum Data Set (MDS) dated 04/23/20 assessed Resident #166 as moderately intact cognition for daily decision making. She required extensive two-person assistance with bed mobility, transfers, dressing and toilet use. Resident #166 was coded for having a surgical wound. Review of a Medical Director's (MD) note dated 04/23/20 revealed Resident #166 was seen on this date for a new admission evaluation. The note revealed her wound vac was in place and her current level of care was stable. The note revealed Resident #166 was frail, and geriatric syndromes included functional decline. The MD	F 600	staff by reviewing all nursing progress notes. In addition, treatment nurse is responsible to ensure that treatments are completed as ordered. If the treatment nurse is unavailable, the Director of Nursing (DON) will complete these tasks and/or assign them to another nurse to complete. An audit tool was developed to ensure the above process was being completed. This audit tool included the following: Is there a physician□s order for treatment of the wound? Are the treatments completed as ordered? Have any signs and symptoms of infection, including redness, increased drainage, foul smelling drainage, elevated temperatures, change in mental status, decline in status and resident refusals of care been reported to the MD/NP and resident representative immediately. The Director of Nursing will audit 25% of residents with wounds weekly x 4 weeks, then biweekly x 4 weeks, then monthly x 1 month. The results of these audits will determine the need for further monitoring. Quality Assurance Performance Improvement The Director of Nursing will bring the results of the audits to the Quality Assurance and Performance Improvement Committee for further review and recommendation. Completion Date June 7, 2021.	

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stated her functional strength and assessment were good and the resident was a full code. Resident #166 was walking with full assist on admission and was a good candidate for Physical Therapy, Occupational Therapy and Speech Therapy. The plan for Resident #166's wound care was to follow up with the surgeon as directed.

Review of Resident #166's TAR and nursing progress notes revealed no evidence of the wound vac being changed or any wound care or treatments to her abdominal surgical wound completed on 04/27/20 and 04/29/20.

Review of a nursing progress note dated 04/29/20 revealed the Physician was made aware that Resident #166 had experienced an 8.3-pound weight loss and swelling in her lower extremities. Resident #166 had refused to get up with Physical Therapy on this date.

Review of a Surgeon's office note dated 04/29/20 revealed Resident #166 was seen on this date in their office for a post-op follow up after an exploratory laparotomy and right colectomy for an incarcerated incisional hernia with perforated cecum. The note revealed her wound vac was in place at the time of the evaluation along with two drains in her old right abdominal wall hernia. The note revealed Resident #166 was doing well and her drains were removed during the visit. A follow up appointment was scheduled for 4 weeks and no concerns were noted during the visit.

Review of Resident #166's Physician orders revealed an order dated 04/29/20 which read, "Right lower abdominal drain sites: cleanse with wound cleanser and apply a dry dressing one a

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day every other day".

Review of Resident #166's May 2020 TAR revealed the order to cleanse Resident #166's right lower abdominal drain sites with wound cleanser and apply a dry dressing were initialed as being changed by Nurse #1 on 05/01/20, and 05/05/20. There was no documentation on the date of 05/03/20 that the dressing was changed, and it was documented on 05/07/20 Resident #166 had refused.

Review of Resident #166's TAR revealed no evidence of the wound vac being changed or any wound care or treatments to her abdominal surgical wound completed on 05/01/20.

Review of a nursing progress note dated 05/01/20 revealed the nurse had went in to talk with Resident #166 regarding nutrition and the importance of eating to aide in recovery. Resident #166 denied any pain at that time. The note revealed Resident #166 did take several sips of the fluids that were offered.

Review of Resident #166's TAR revealed no evidence of the wound vac being changed or any wound care or treatments to her abdominal surgical wound completed on 05/04/20.

Review of a nursing progress note dated 05/5/20 written by Nurse #1 (Treatment Nurse) at 11:29 AM revealed a foul odor was noted to Resident #166's wound with a large amount of yellow drainage. The note revealed she left a voicemail for Resident #166's Surgeon's office to contact the facility regarding any new orders or updates.

Review of Resident #166's medical record

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revealed no documentation of Physician notification on 05/05/20 regarding the residents wound vac not being changed as ordered since her admission on 04/21/20 or the large amount of drainage coming from the wound.

Review of Resident # 166's TAR for May 2020 revealed an order to change the residents wound vac twice weekly on Mondays and Thursdays initiated on 05/05/20 (Tuesday) by Nurse #1. The wound vac was scheduled to be changed was on Thursday 05/7/20. Nurse #1 initialed the TAR on 05/07/21 and indicated Resident #166 refused as indicated by parenthesis around her Nurse #1's initials.

On 05/05/21 at 8:58 AM an interview was conducted with Nurse Aide (NA) #4. During the interview she stated she did not recall Resident #166. When reminded by the surveyor that she took care of the resident a year ago on 05/05/20 and throughout her stay she stated she still did not recall Resident #166.

On 05/05/21 at 8:59 AM an interview was conducted with Nurse #13. During the interview she stated she did not recall Resident #166. When reminded by the surveyor that she took care of the resident a year ago on 05/05/20 and during her stay in the facility she still stated she did not recall Resident #166.

Review of a nursing progress note dated 05/08/20 written by Nurse #1 at 11:02 AM revealed she had gone into Resident #166's room to assess her wound vac functioning. A 5 centimeter (cm) by 5 cm discolored area was noted to her right abdomen. The Nurse Practitioner was noted to be in the building and

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made aware.

On 05/04/21 at 9:32 AM an interview was conducted with Nurse #10. During the interview she stated she did not recall Resident #166. When reminded by the surveyor she was the resident's nurse on the date of 05/08/20 she stated she did not recall the situation or the resident.

Review of a nursing progress note dated 05/08/20 written by Nurse #1 at 11:30 AM revealed the Nurse Practitioner was made aware of the wound changes and was in the room assessing Resident #166. Orders were received to send Resident #166 to the hospital related to an abdominal wound infection.

Review of a Nurse Practitioner (NP) note dated 5/8/20 at 12:29 PM revealed he was notified by Nurse #1 who was concerned Resident #166's wound was getting worse. Resident #166 was experiencing altered mental status, a decline in appetite, decline in her wound and overall abdominal pain. The note stated the NP was sending the resident to the hospital, given the progression, or worsening of her abdominal incision with slough he felt the wound needed to be debrided (procedure to clean the wound a remove any necrotic or dead tissue) by a surgeon.

Review of Resident #166's May 2020 TAR revealed an order dated 05/08/20 which read, "Abdomen surgical site: Cleanse with normal saline, apply wet to dry dressing using normal saline one time prior to sending the resident to the Emergency Department". The order was initialed as being completed by Nurse #1.

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Review of Resident #166's hospital records dated 05/08/20 revealed Resident #166 presented to the Emergency Department with fever, malaise, foul smelling drainage from her right flank and complaints of pain. She had an opened midline abdominal surgical incision with purulent (thick, milky) drainage. In addition, there was a large area of fluctuance (tense area of skin with a wave-like or boggy feeling) and erythema (redness) on the right flank with suspected skin necrosis. Resident #166 was diagnosed with necrotizing fasciitis (a serious bacterial infection that destroys tissue under the skin) after undergoing an emergent debridement of an abscess and necrotic tissue. Resident #166's hospital diagnosis included abdominal wall abscess, septic shock, open abdominal wall wound, abdominal pain and necrotizing fasciitis. The hospital records revealed Resident #166 had been in the state of persistent shock since arrival to the Emergency Department continuing to require high doses of vasopressors (medication given to increase blood pressure) even with aggressive resuscitation. The note stated, "it would be difficult for a young healthy person to survive a necrotizing infection this extensive and that involved this much of her abdominal wall". Orders were placed to proceed with terminal extubation (removal of an artificial ventilation tube) and comfort care.

Review of Resident #166's death certificate revealed she expired on 05/15/20 due to necrotizing fasciitis, sepsis, perforated intestines and an incarcerated hernia.

On 05/05/21 at 9:12 AM an interview was conducted with the Clinical Coordinator. She

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stated she remembered when Resident #166 came into the facility she had a poor appetite. The interview revealed she did not recall anything else about Resident #166 even though she was the charge nurse during her stay in the facility. She stated any nurse in the building could change a wound vac and if Nurse #1 was scheduled to work on a resident hall it was the nurse on the halls responsibility to change the resident's dressings.

On 05/03/21 at 3:33PM an interview was conducted with Nurse #1. She stated on 4/21/20 Resident #166 was admitted into the facility in need of a wound vac placement so she put in an order to initiate the wound vac as soon as the resident arrived into the facility. She stated based on her hospital discharge summary the facility was supposed to change her wound vac three times weekly. She stated the charge nurse would have been the one putting that order in however it had been missed. The interview revealed the time frame was during the COVID-19 pandemic and Nurse #1 was the treatment nurse and was being pulled to a hall to work so she wasn't doing all of the treatments or handling wound care. Nurse #1 explained she didn't realize Resident #166's wound vac hadn't been changed since her admission until on 05/05/20 (Tuesday) when the resident was noted to have foul smelling drainage at her abdominal incision site. She stated she notified the surgeons office and placed an order to change the residents wound vac twice a week because she never heard back from the surgeon's office. She indicated she did not go ahead and change the wound vac on 05/50/20 but scheduled the order for Mondays and Thursdays. The interview revealed when she went into the room on 05/07/20 to change the

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wound vac Resident #166 stated she felt bad and did not want it changed. Nurse #1 stated she was informed on 05/08/20 Resident #166 was acting differently so she notified the in-house Nurse Practitioner to come and look at her incision site. Once he saw the site, he gave orders to send the resident to the hospital for an evaluation. The interview revealed that normally wound vacs would be changed either twice weekly or three times a week based on the Physician's orders.

On 05/05/21 at 2:06 PM an interview was conducted with the Surgeon's Nurse Practitioner (NP). She stated upon Resident #166's hospital discharge she had put in orders for the residents wound vac to be changed on Mondays, Wednesday and Fridays while at the facility. The NP stated she couldn't speak to anything else regarding the resident's care that the Surgeons office always ordered the wound vacs to be changed two to three times weekly following surgery.

On 05/05/21 at 2:32 PM an interview was conducted with Resident #166's Surgeon. He stated his office always ordered for wound vacs to be changed twice weekly or three times weekly. He stated he couldn't speak to the situation because he did not see Resident #166 on 05/08/20 before she went to the hospital. The interview revealed slough would be normal to see in a wound that a wound vac was applied even if the wound vac wasn't change as ordered. He stated if the wound vac was working accordingly it would not have caused an infection even if the nurses were not changing it as he ordered. His expectation was for the facility to follow wound care orders provided on a resident's discharge summary.

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On 05/06/21 at 4:52 PM an interview was conducted with the Director of Nursing (DON). During the interview he stated Resident #166's wound vac should have been changed per Physician's orders while she was in the facility. The interview revealed any of the nurses in the facility could change a wound vac.

On 05/05/21 at 9:35 AM an interview was conducted with the facility Medical Director (MD). During the interview he stated he did not recall the resident and could not believe the surveyor was asking him to recall from one year prior. He stated he would have to review his notes and call the surveyor back at the end of the day.

On 05/06/21 at 3:45 PM an second interview was conducted with the MD. During the interview he stated he was driving and hadn't had time to review the resident's chart.

On 05/14/21 at 11:32 AM a voicemail was left for the MD by the surveyor asking for a return phone call.

On 05/18/21 at 8:58 AM an interview was conducted with the MD. During the interview he stated the Surgeon's orders were not adhered to regarding wound care and he thought it was a facility process issue. The interview revealed based on hospital records he felt the resident was still high risk regardless of wound care issues. He stated he couldn't speak to if having her wound vac changed per the Surgeon's orders would have changed the resident's outcome. The MD stated there was an issue with lack of follow through by the facility which needed to be addressed in the Quality Assurance meetings.

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The facility Administrator was notified of the immediate jeopardy on 05/06/21 at 3:35 PM.

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

Resident #166 was admitted into the facility on 4/21/2020 following a hospital admission where she underwent an exploratory laparotomy and right colectomy for an incarcerated incisional hernia with perforated cecum. Admitting diagnosis included hernia, peritonitis, and hypertension.

Resident #166 ' s hospital discharge summary dated 4/21/2020 revealed she would need her wound vac to her midline abdominal surgical incision changed three times a week on Monday, Wednesdays and Fridays.

Facility failed to change Resident #166's wound vac from 4/22/2020 to 5/8/2020. The nurse failed to enter the orders for the dressing change into the electronic health record. The Treatment Nurse noted a foul odor was noted to Resident #166's abdominal wound with a large amount of yellow drainage on 5/5/2020. She didn't realize Resident #166's wound vac hadn't been changed since her admission until 5/5/2020 and stated she notified the surgeons office but never heard back from the surgeon's office. She stated she did not go ahead and change the wound vac on 5/5/2020 but scheduled the order for Mondays and Thursdays because she was scheduled to work on another hall that day and wasn't doing treatments. On 5/7/2020 the Treatment Nurse failed to notify the Physician that Resident #166

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had refused the dressing change and was still experiencing a foul odor and drainage from her abdominal wound.
On 5/8/2020 a nursing assistant (NA) notified the treatment nurse that the resident was acting differently than usual. The treatment nurse came into the room to assess Resident 166 and continued to note a foul odor coming from her wound. She notified the Nurse Practitioner who was in the building. Resident #166 was seen by the Nurse Practitioner (NP) on 5/8/2020 who noted the resident had altered mental status with an overall decline in appetite and was experiencing abdominal pain. The NP note stated given the progression or worsening of the abdominal incision even with wound vac Resident #166 was noted to have slough and sutures present. The NP felt the wound needed to be debrided by a surgeon at the hospital. Orders were given to send Resident #166 for an evaluation.
Resident #166 presented to the Emergency Department with fever, malaise, foul smelling drainage from her right flank and complaints of pain. She had an opened midline abdominal surgical incision with purulent drainage. In addition, there was a large area of fluctuance and erythema on the right flank with suspected skin necrosis. Resident #166 was diagnosed with necrotizing fasciitis after undergoing an emergent debridement of an abscess and necrotic tissue. Resident #166 expired on 5/15/2020 due to necrotizing fasciitis, sepsis, perforated intestines, and an incarcerated hernia.

An audit was completed by the Administrator, Staff Development Coordinator (SDC), Treatment Nurse and Director of Nursing on 5/06/2021 of all residents to check for the following items: Does

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the resident have a wound? Are appropriate treatment orders in place? Have the treatments been completed as ordered? Are there signs and symptoms of infection or worsening condition? Has the physician been notified of worsening condition? There were no additional residents identified as having been affected by the alleged deficient practice.

#2. 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.

On 5/6/2021, The treatment nurse was educated by the Administrator on responsibilities to ensure that all wounds are assessed upon admission and that appropriate physician orders are in place for treatments for all wounds. The Treatment Nurse will review all new admissions daily to ensure that any resident wounds have appropriate physician orders for treatments. Treatment nurse will also review the Facility Activity Report in the electronic health record daily to see if any new wounds have been identified by nursing staff by reviewing all nursing progress notes. In addition, treatment nurse is responsible to ensure that treatments are completed as ordered. If the treatment nurse is unavailable, the Director of Nursing (DON) will complete these tasks and/or assign them to another nurse to complete. The DON was notified of this responsibility on 5/7/2021 by the Administrator.

All licensed nursing staff will be educated by the Administrator, Corporate Nurse Manager, and/or the Staff Development Coordinator on the following: Implementation of treatment orders, management and care of wounds, signs and

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symptoms of wound complications, regular wound assessment, to report signs and symptoms of infection, including redness, increased drainage, foul smelling drainage, elevated temperatures, change in mental status, decline in status and resident refusals of care to the MD/NP and resident representative immediately. This will be completed by 5/7/201.

All CNAs will be educated by the Administrator, Staff Development Coordinator, Treatment Nurse and/or DON on monitoring residents for declines and changes in conditions and how to respond to resident refusals and to report signs and symptoms of infection, including redness, increased drainage, foul smelling drainage, elevated temperatures, change in mental status and decline in status and to report these findings to the nurse immediately. This will be completed by 05/07/2021.

Any licensed nurse or Certified Nursing Assistant out on leave or on PRN status will be educated prior to returning to duty by the Director of Nursing, Staff Development Coordinator, and/or the Treatment Nurse. The Director of Nursing, Staff Development Coordinator and the Treatment Nurse were advised of this responsibility on 05/06/2021. The SDC will be responsible for tracking staff that have not received the education. Any newly hired licensed nurse will be educated during orientation by the Staff Development Coordinator. The DON will ensure that this process is followed.

The Administrator and Director of Nursing will be responsible for oversight of this plan and ensure compliance with training.

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F 600	Continued From page 41 TITLE OF THE PERSON RESPONSIBLE FOR IMPLEMENTING THE CREDIBLE ALLEGATION FOR IMMEDIATE JEOPARDY REMOVAL. The Administrator and the Director of Nursing will be ultimately responsible to ensure the implementation of credible allegation to remove this alleged immediate jeopardy. Immediate Jeopardy Removal Date: 5-07-2021 On 05/14/21, the facility's credible allegation of immediate jeopardy removal was validated by review of documentation regarding staff training of the importance of implementing Physician orders and management of wounds. Staff interviews revealed receipt of training related to implementing Physician orders, management of wounds, Physician notification regarding resident refusals and noticing a change of condition. The facility's date of IJ removal of 05/07/21 was validated.	F 600		
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	F 656		6/7/21

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F 656	Continued From page 42 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)- (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 a comprehensive, individualized, and person- centered care plan in the area of surgical wound for 1 of 3 sampled residents reviewed for wounds (Resident #166). The findings included: 1. Resident #166 was admitted into the facility on 4/21/20 following a hospital admission where she underwent an exploratory laparotomy and right	F 656	F656 Residents affected: Residents # 166 suffered no physical adverse effects related to the staffs alleged deficient practice. Resident #166 transferred to the hospital on May 8, 2021 and did not return to the facility.	

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F 656	Continued From page 43 colectomy for an incarcerated incisional hernia with perforated cecum. The admission Minimum Data Set (MDS) dated 04/23/20 assessed Resident #166 as moderately intact cognition for daily decision making. She required extensive two-person assistance with bed mobility, transfers, dressing and toilet use. Resident #166 was coded for having a surgical wound. Review of Resident #166's care plan dated initiated on 04/28/20 revealed no focus area for a surgical wound. Review of Resident #166's hospital discharge summary dated 4/21/20 revealed she would need her wound vac to her midline abdominal surgical incision changed three times a week on Monday, Wednesdays and Fridays. Review of Resident #166's Skin Integrity Review dated 4/21/20 revealed she had a 6-inch surgical site to her midline abdomen which was packed with gauze. Review of Resident #166's April 2020 Physician orders revealed an order initiated on 04/21/20 which read, "Apply wound vac to residents' surgical site (mid abdomen) as soon as she arrived in the facility". On 05/05/21 at 3:04 PM an interview was conducted with the MDS Nurse. She stated she had been in the facility since February 2021 filling in since the facility did not have a MDS Nurse. The interview revealed MDS nurses from sister facility had been helping fill in for the facility. She stated she couldn't speak to what had happened	F 656	Other residents with potential to be affected Audit was completed by Minimum Data Set (MDS) on May 26, 2021. 100% audit was conducted on all residents' wounds to ensure that care plan was specific to the wounds. There were no additional residents identified as having been affected by the alleged deficient practice. System changes: On May 25, 2021, the Minimum Data Set (MDS) nurse was educated by Regional Nurse Manager on responsibilities to ensure comprehensive individualized, and person- centered care plan are in place for all residents. MDS Nurse was educated to ensure that residents with wounds have focus area specific to the wound, and that resident's progress notes will be reviewed daily Monday through Friday in morning clinical meeting to ensure that any new wound has a careplan with a focus area specific to that wound. Monitoring: Audit tool developed was developed and initiated on May 25, 2021 to ensure that residents with wounds have focus area on care plan. Audit tool consists of the following: (1) Are the surgical/focus area identified on care plan for all wounds?	

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F 656	Continued From page 44 in the past however if a resident was admitted to the facility now with a surgical wound it would be incorporated into their care plan because its important especially having agency staffing in the building for them to be able to look at the care plan and have a clear picture of what the resident needs. Interventions should have been included into Resident #166's care plan in accordance to her treatment needs and wound vac changes. On 05/06/21 at 6:00 PM an interview was conducted with the Administrator. During the interview she stated she would have expected her staff to incorporate a care plan directly reflecting Resident #166 and including her surgical wound.	F 656	Regional Nurse will audit 25% of residents with wounds careplans weekly for 4 weeks; 25% every other week for 4 weeks; then 25% monthly x 1 month. The Regional Nurse will select residents for the audit by reviewing the facility's current wound log. The need for further monitoring will be determined by the prior month of auditing. Quality Assurance and Performance Improvement: The MDS Coordinator will bring results to the Quality Assurance and Performance Improvement Committee for review and further recommendations. Completion date June 7, 2021.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's	F 657		6/7/21

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F 657	Continued From page 45 medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with family member and staff, the facility failed to revise Resident #47's care plan to reflect non-compliance with medications for 1 of 5 residents (Resident #47) reviewed for medication administration. The findings included: Resident #47 was admitted to the facility on 7/1/19 with diagnoses that included congestive heart failure (CHF), chronic kidney disease and schizophrenia. A review of Resident #47's medical record revealed the following progress notes: *3/17/21 at 10:46 PM - Behavior note written by the Clinical Coordinator: Nurse in resident room to administer medications. Resident poured medicines out of cup into her hand and pretended like she took the pills. Nurse noticed the pills were still in her hand. Resident did this on first and second medication pass this shift. Nurse notified the responsible party (RP) of resident behavior. The RP stated she would speak with resident about it. Resident was also educated on	F 657	F657 Residents affected: Residents #47 suffered no physical adverse effects related to the staffs alleged deficient practice. Resident #47 remains in the facility with no residual adverse effects. Other residents with potential to be affected Audit was completed by Minimum Data Set (MDS) Nurse on May 26, 2021 to ensure other residents were not affected by the deficient practice. 100% of all residents' care plans related to resident with refusal of medication were reviewed. 22 residents were affected from the deficient practice. All residents care plan were updated to reflect refusing medications by MDS Nurse on May 26, 2021.	

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F 657	Continued From page 46 the importance of medications. Resident verbalized understanding, then started crying and stated that she didn't mean to. *3/23/21 at 12:47 PM - Interdisciplinary Team Meeting to review antipsychotic medication: Resident also noted to have poured medicines out of cup into her hand and pretended like she took the pills. The nurse noticed the pills were still in her hand. Resident was educated and responsible party notified. The Quarterly Minimum Data Set (MDS) assessment dated 4/14/21 indicated Resident #47 was cognitively intact and exhibited no rejection of care behaviors. Resident #47's care plan last reviewed on 4/29/21 indicated that she often refused medications. Interventions included the following: assess ability to make informed decision about her care, consider psychiatric referral related to possible mood/behavior associated with refusals, give positive feedback for compliance, inform resident/family about risks associated with refusal, notify physician when applicable if resident refusal could be detrimental to her health/plan of care, staff to continue to offer routine care and services to resident and accept her right to refuse and document interventions. The care plan did not include interventions to address Resident #47's behavior of placing her medications in her hand while making the nurse think that she had already taken her medications. A phone interview with Resident #47's family member on 5/3/21 at 6:32 PM revealed she had just been to the facility to pick up Resident #47's dirty laundry and found some pills in the pocket of	F 657	System Changes: MDS Nurse educated by Regional Nurse Manager on ensuring careplans reflect the behavior of refusing medications on the care plan and approaches are specific for the resident. The MDS Nurse will review progress notes and behavior monitoring documentation to ensure that any refusals of medications are careplanned timely. This will be completed by May 26, 2021. Monitoring: Audit tool was developed to monitor careplans for residents refusal of care/medications and that careplan has been updated timely. Audit tool consists of the following: (1) Care plan reflects behaviors for refusal of medication. (2) Care plans are updated timely. Regional Nurse Manager will audit 25% of resident care plans with refusal of care/medications weekly x 4 weeks; then every other week for 4 weeks, then monthly x 1 month. The need for further monitoring will be determined by the prior month of auditing. The Regional Nurse Manager will obtain the pool of residents to audit by reviewing documentation in progress notes and behavior monitoring documentation. Quality Assurance and Performance Improvement	

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F 657	Continued From page 47 one of her clothes. Resident #47's family member stated the nurses probably tried to give Resident #47 her medications but didn't watch her swallow all her pills. She added that if the nurses did not watch Resident #47 swallow her pills, she would not take them by herself. An interview with the Clinical Coordinator (CC) on 5/4/21 at 3:00 PM revealed Resident #47 had a history of keeping her pills in her hand and making the nurse think that she had already taken them. The CC stated she had noticed her doing this a couple of times when she had to give her medications. An interview with the interim MDS Coordinator on 5/5/21 at 3:04 PM revealed they last held Resident #47's care plan meeting on 4/29/21. She did not recall Resident #47's non-compliant behaviors during medication administration being discussed at the meeting. The interim MDS Coordinator disclosed that she did not review Resident #47's progress notes prior to the meeting and stated she only did so when the family member had questions regarding the resident's care. The interim MDS Coordinator stated she would have added Resident #47's non-compliant behaviors regarding her medications in her care plan if this issue was brought to her attention and after finding out that it had happened several times recently before the care plan meeting. An interview with the interim Director of Nursing (DON) on 5/5/21 at 1:30 PM revealed he had taken care of Resident #47 and was familiar with her habit of making the nurse think that she had already taken her medications but she had kept them in her hand. The interim DON stated the	F 657	The MDS Coordinator will bring results to the Quality Assurance and Performance Improvement Committee for review and further recommendations. Completion date June 7, 2021.	

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F 657	Continued From page 48 nurses should have been paying attention to Resident #47 and making sure that she took all her medications. He also stated that this information regarding Resident #47's non-compliant behavior during medication administration should be communicated by the nurses to each other during shift exchange as well as in her care plan. The interim DON added that they utilized medication aides and agency nurses who might not be familiar with Resident #47 and her medication habits so this information should be included in her care plan. An interview with the Administrator on 5/6/21 at 5:40 PM revealed Resident #47's care plan should have been updated to include her non-compliant behavior related to taking her medications and how to address them.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews the facility failed to provide showers as scheduled for a dependent resident for 2 of 6 residents sampled for activities of daily living (ADL) (Resident # 46 and Resident # 58). The findings included: 1. Resident # 46 was admitted to the facility on 8/22/2017 with diagnosis of Cerebrovascular Accident (CVA or Stroke) and Chronic Obstructive	F 677	F677 Residents affected: Residents #46 and Resident #58 suffered no physical adverse effects related to the staffs alleged deficient practice. All residents listed remains at the facility with no residual adverse effects. Other residents with the potential to be	6/7/21

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F 677	Continued From page 49 Pulmonary Disease (COPD) with tracheostomy (a surgically created opening through the front of the throat to the windpipe). A review of the quarterly Minimum Data Set (MDS) dated 4/14/2021 revealed Resident # 46 required extensive assistance of two persons for bed mobility. The resident required extensive assistance of one person for dressing and eating. Resident # 46 was totally dependent on one person for bathing, could not ambulate, and required use of a mechanical lift for transfers. Resident # 46 was non-verbal and severely cognitively impaired. A review of the shower schedule revealed Resident # 46 was to receive a shower on Tuesdays and Fridays on second shift. A review of the April 2021 ADL report showed Resident # 46 received 29 bed-baths, 11 partial bed-baths and 4 showers. Based on the schedule, Resident # 46 should have received 9 showers in the month of April 2021. An observation of Resident # 46 was made on 5/3/2021 at 1:20 PM. Resident # 46 was lying on her back in bed with her eyes open. Her hair was askew with white flakes along the hairline above her right ear. There were copious clear secretions on her chest below her tracheostomy. Resident # 46 did not respond to voice. An observation of Resident # 46 was made on 5/4/2021 at 8:00 AM. The resident was lying on her back with eyes and mouth open. Her mucus membranes were moist with evidence of dried secretions to the corners of her lips. Large white flakes were present in her hairline above her right ear. Her hair was disheveled.	F 677	affected: Audit was conducted by Staff Development Coordinator and Licensed Practical Nurse (LPN) in Charge to ensure no other residents were affected by the deficient practice. Audit was completed on May 27, 2021 related to hair care and showers. All residents (100%) were checked to see if they received showers as scheduled, including hair care. It was noted that 9 residents were affected by the deficient practice. The affected residents had their hair washed with head and shoulders and/or t-gel orders. All other residents received showers as scheduled. No resident was adversely affected by the alleged deficient practice. System Changes: All nursing staff and contracted nursing staff will be educated by Staff Development Coordinator regarding maintaining grooming and personal hygiene and to complete resident showers as scheduled. Completed showers and any refusal of showers will be documented in the electronic health record. Nursing assistants will notify the nurse in charge of the resident that the resident has refused the scheduled shower. Education will be completed by June 7, 2021. All nursing staff out on leave or PRN status will be educated by the Staff Development Coordinator and/or designee prior to returning to duty. Any	

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F 677	Continued From page 50 An observation of Resident # 46 was made on 5/5/2021 at 3:00 PM. Resident # 46 was lying on her back with eyes and mouth open. Resident # 46's mucus membranes appeared moist and there was no evidence of dried secretions in the corners of her lips. Large white flakes were present in her hairline above her right ear. Her hair had a slightly greasy appearance. An observation of Resident # 46 was made on 5/6/2021 at 10:16 AM. Resident # 46 was on her back in bed with her eyes and mouth open. Her hair was greasy and had large white flakes along the hair line above her right ear. An observation of Resident # 46 was made again on 5/6/2021 at 2:10 PM. She continued to have large white flakes in her hair above the right ear. Her hair remained greasy and unkempt. Her face showed dry flaky skin on her right cheek and forehead. Her lips were dry and cracked. An interview was conducted on 5/5/2021 at 11:40 AM with Nurse Aide (NA) # 7. She revealed she was regularly assigned to the hall on which Resident # 46 resided. She verbalized that a shower consisted of a resident being taken to the shower room and bathed either in a shower chair or a shower stretcher. She stated a shower included hair care and washing of the face and body. She stated Resident # 46 was scheduled for showers on Tuesdays and Fridays on second shift. NA # 7 stated she did not know when Resident # 46 had last had a shower or her hair washed. She stated shampoo caps were available to provide hair care for residents outside of shower days. NA # 7 revealed there were not enough NAs available to ensure residents	F 677	newly hired nursing staff or contracted staff will be educated during orientation by the SDC. Monitoring: An audit tool was developed to monitor showers to ensure they are provided to the resident as scheduled. Alert and oriented residents will be interviewed. Cognitively impaired residents who cannot verbalize if a shower was given will be observed for cleanliness and grooming. Documentation of completed and refused showers will be monitored as well to ensure compliance. The Director of Nursing, Staff Development Coordinator and/or designee will audit 5 residents weekly x 4 weeks, then every other week x 4 weeks, then monthly x 1 month. These audits will occur on random days and shifts, including weekends. The need for further monitoring will be determined by the prior month of auditing. Quality Assurance Performance Improvement The Director of Nursing and/or Staff Development Coordinator will bring results to the Quality Assurance and Performance Improvement Committee for review and further recommendations. Completion date June 7, 2021	

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F 677	Continued From page 51	F 677		

received their showers as scheduled. NA # 7 indicated that showers could not be passed off to the next shift as they were short of staff as well. She stated she did not tell the hall nurse when she did not administer all of her assigned showers.

An interview was conducted on 5/5/2021 at 3:30 PM with Nurse # 11. She revealed she was a PRN employee who had previously worked full-time at the facility. She was familiar with Resident # 46. She stated she had not been notified during any of her shifts that showers were not given. She revealed missed showers were to be reported to the Director of Nursing (DON).

An interview was conducted on 5/6/2021 at 2:10 PM with Nurse # 9. She revealed she was regularly assigned to the hall on which Resident # 46 resided. She stated she had no reports from NAs that showers were not being given.

An interview was conducted on 5/6/2021 at 2:20 PM with NA # 9. She revealed she was regularly assigned to the hall on which Resident # 46 resided. NA # 9 stated she often had to give a bed bath in place of a shower because there was not enough help. She stated she was aware that shower caps and waterless shampoo were options, but she did not know if they were available at the facility. NA # 9 stated she did not always let the nurse know if showers were not completed.

An interview was conducted on 5/6/2021 at 4:30 PM with the DON. He stated if staffing did not allow a shower for a resident on their scheduled day, it should be given the next day. He further stated, "hair washing is part of a shower." When

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F 677	Continued From page 52	F 677		

informed that Resident # 46 had only received 4 of 9 scheduled showers in the month of April, he stated, "that is not acceptable." He further stated, "not providing showers and not washing hair is deficient practice and we have a dilemma."

An interview was conducted on 5/6/2021 at 6:00 PM with the facility Administrator. She stated showers, including hair care should be happening. She stated she was not aware that showers were not being given as scheduled.

2. Resident # 58 was admitted to the facility on 8/22/2017 with diagnoses of Multiple Sclerosis (MS) and neurogenic bladder.

A review of her annual Minimum Data Set (MDS) dated 4/2/2021 revealed Resident # 58 required extensive assistance of one person for bed mobility, dressing, eating, and personal hygiene. She was totally dependent on two persons for transfers, toileting, and bathing. Resident # 58 could not ambulate and required a mechanical lift for transfers. She was mildly cognitively impaired.

A review of the shower schedule revealed Resident # 58 was scheduled to receive a shower on Wednesdays and Saturdays on first shift. A review of the April 2021 ADL report showed Resident # 58 received 12 bed-baths, 7 partial bed-baths and 6 showers during the month of April. Based on the schedule, Resident # 58 should have received 8 showers in the month of April 2021.

An observation of Resident # 58 was made on 5/2/2021 at 1:15 PM. She was in her room, seated upright in a wheelchair with her hands in

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F 677	Continued From page 53	F 677		

her lap. Her eyes were closed. Her hair was in a ponytail with white flakes visible in her hair along the top of her head.

An observation of Resident # 58 was made on 5/2/2021 at 3:35 PM. She remained upright in her wheelchair. Her eyes were open, and she responded to some questions. She states a "lady" painted her fingernails for her. Her nails were long, but manicured. Resident # 58 stated she could not recall when she last had a shower or had her hair washed.

An observation of Resident # 58 was made on 5/3/2021 at 2:25 PM on return from a medical appointment. She was upright in her wheelchair, with a surgical mask in place. There were blankets across her lap. Her eyes were closed. Her hair was braided into two buns on the top of her head. There were no white flakes in her hair during that observation.

An observation of Resident # 58 was made on 5/4/2021 at 8:00 AM. She was lying in her bed, positioned on her right side. Wound care and incontinence care were observed during that encounter. White flakes were again present in her hair.

An observation of Resident # 58 was made on 5/5/2021 at 2:45 PM. She was lying in her bed leaning slightly on her right side, with her eyes closed. Her hair was pulled back into a ponytail. Her hair appeared to be free of flakes. She did not respond to voice.

An observation of Resident # 58 was made on 5/6/2021 at 2:10 PM. She was sitting upright in her wheelchair; her eyes were open. Her hair

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F 677	Continued From page 54	F 677		

was again pulled back in a ponytail. No flakes were visible in her hair. She was talkative during this encounter, and again stated she did not recall when she had her last shower or hair washing.

An interview was conducted on 5/5/2021 at 11:40 AM with Nurse Aide (NA) # 7. She revealed she was regularly assigned to the hall on which Resident # 58 resided. She verbalized that a shower consisted of a resident being taken to the shower room and bathed either in a shower chair or a shower stretcher. She stated a shower included hair care and washing of the face. She stated Resident # 58 was scheduled for showers on Wednesdays and Saturdays on first shift. NA # 7 stated she did not know when Resident # 58 had last had a shower or her hair washed. She stated shampoo caps were available to provide hair care for residents outside of shower days. NA # 7 revealed there were not enough NAs available to ensure residents received their showers as scheduled. NA # 7 indicated that showers could not be passed off to the next shift as they were short of staff as well. She stated she did not tell the hall nurse when she did not complete all of her assigned showers.

An interview was conducted on 5/5/2021 at 3:30 PM with Nurse # 11. She revealed she was a PRN employee who had previously worked full-time at the facility. She was familiar with Resident # 58. She stated she had not been notified during any of her shifts that showers were not given. She revealed missed showers were to be reported to the Director of Nursing (DON).

An interview was conducted on 5/6/2021 at 2:10 PM with Nurse # 9. She revealed she was regularly assigned to the hall on which Resident #

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F 677	Continued From page 55 58 resided. She stated she had no reports from NAs that showers were not being given. An interview was conducted on 5/6/2021 at 2:20 PM with NA # 9. She revealed she was regularly assigned to the hall on which Resident # 58 resided. NA # 9 stated she often had to give a bed bath in place of a shower because there was not enough help. She stated she was aware that shower caps and waterless shampoo were options, but she did not know if they were available at the facility. She stated she did not always let the nurse know if showers were not completed. An interview was conducted on 5/6/2021 at 4:30 PM with the DON. He stated if staffing did not allow a shower for a resident on their scheduled day, it should be given the next day. He further stated, "hair washing is part of a shower." When informed that Resident # 58 had only received 6 of 8 scheduled showers in the month of April, he stated, "that is not acceptable." He further stated, "not providing showers and not washing hair is deficient practice and we have a dilemma." An interview was conducted on 5/6/2021 at 6:00 PM with the facility Administrator. She stated showers, including hair care should be happening. She stated she was not aware that showers were not being given as scheduled.	F 677		
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary,	F 685		6/10/21

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F 685	Continued From page 56 assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on record review, observation, resident interviews, and staff interviews the facility failed to facilitate an eye appointment for 1 of 1 resident reviewed for vision (Resident #31). The findings included: Resident #31 was admitted to the facility on 07/01/2019 with diagnosis which included type 2 diabetes and glaucoma. Review of progress note dated 03/06/20 revealed Resident #31 was scheduled to see an optometrist in the facility in April but was canceled due to Covid. Review of progress note dated 08/18/20 revealed the facility Social Worker was called to Resident #31's room to discuss eye pain and the resident was seeing double. The Social Worker offered Resident #31 an eye appointment but stated the resident would have to quarantine after going out of the facility for an appointment. Resident #31 did not want to attend this appointment due to having to be quarantined. Review of Resident #31 quarterly minimum data set (MDS) 03/16/21 revealed Resident #31 was	F 685	F685 Residents affected: Resident # 31 did express having issues with seeing double and would like for her eyes and glasses to be checked. Social Worker followed up with Resident #31 on May 5, 2021 to set up appointment with external optometrist. Resident #31 declined service and stated she would wait on the optometrist that visits the facility. Optometrist is scheduled to visit facility on July 14, 2021. Other residents with the potential to be affected: All other visually impaired residents were reviewed to determine if resident was experiencing any issues with vision and/or glasses. This review was conducted by the Social Worker on May 18, 2021. It was determined that no other residents were adversely affected by the alleged deficient practice. System Changes:	

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F 685	Continued From page 57 cognitively intact needing limited assistance with majority of activities of daily living (ADL). The MDS further revealed Resident #31 wore corrective lenses. Observation of Resident #31 on 05/03/21 at 2:45 PM revealed Resident #31 putting her glasses on and taking them off shortly due to not being able to see out of them. An interview conducted with Resident #31 on 05/03/21 at 2:45 PM revealed that she does not recall going to see an eye doctor since she has been in the facility. The resident further revealed she did not want to go to her eye appointment back in August because she was told that she would have to be quarantined. Resident #31 stated she has told staff that she was seeing double out of her glasses and would like to have her eyes and glasses checked. An interview conducted with the Social Worker on 05/05/21 at 9:50 AM revealed residents that went out for appointments in August were quarantined. The Social Worker further revealed residents have been going out the last three months for appointments without being quarantined and Resident #31 should have been a priority to see an optometrist. An interview conducted with the Supply Clerk on 05/06/21 at 9:45 AM revealed she schedules outside appointments for residents. It was further revealed the last optometrist appointment scheduled was in August and Resident #31 did not want to be quarantined. The Supply Clerk indicated that no staff since then have come to her to schedule an appointment for Resident #31 to see an optometrist.	F 685	Education was provided to Social Worker by Administrator on May 25, 2021. Education consisted of ensuring all residents receive the proper treatment and assistive devices required to maintain their hearing and vision; ensure that all residents receive vision examinations annually and per request; and ensure that residents with vision issues are referred to optometrist timely. Social Worker will also assist residents with making appointments and arranging transportation to and from appointment. All nursing staff will be educated to report any complaints of vision issues to the Social Worker to schedule an appointment with the optometrist. This education will be completed by June 10, 2021 by the Administrator/Director of Nursing and/or Staff Development Coordinator. Monitoring: Audit tool was initiated to ensure all residents are receiving vision examinations annually and per request and that any resident experiencing vision issues is referred to optometrist timely. The audit was initiated on May 27, 2021. The audit consists of the following: Is the resident experiencing any issues with vision? Has an appointment been made with an optometrist? Has the resident had an annual eye examination? The Social Worker will conduct an audit of	

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F 685	Continued From page 58 An interview was conducted with the Director of Nursing (DON) on 05/06/21 at 4:45 PM revealed Resident #31 did not have to be quarantined if she went out for an appointment in August. The DON further revealed it was expected for Resident #31 to have seen an optometrist within this time. An interview was conducted with the Administrator on 05/06/21 at 5:40 PM revealed Resident #31 should have not been isolated for an outside appointment. The Administrator further revealed Resident #31 was given the wrong information and should have seen an optometrist if she requested to see one.	F 685	10% of residents weekly x 4 weeks, then every other week for 4 weeks, then monthly x 1 month. The need for further monitoring will be determined by the prior month of auditing. Quality Assurance Performance Improvement The Social Worker will bring results to the Quality Assurance and Performance Improvement Committee for review and further recommendations. Completion date June 10, 2021	
F 689 SS=J	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 observation, record review, resident, staff, and corporate nurse interviews, the facility failed to prevent a cognitively impaired resident who wandered and was assessed for being at risk for elopement from exiting the facility unsupervised. This affected 1 of 2 residents (Resident #167) reviewed for supervision to prevent accidents. Resident #167 was located 2 hours and 35 minutes later in the emergency	F 689	F 689 Resident affected Resident #167 returned to the facility from the ER at the local hospital at approximately 7:53 PM and a wanderguard was applied to his ankle by Nurse #2. Other interventions put into	6/7/21

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F 689	Continued From page 59	F 689		

room (ER) of the local hospital where he was treated for a laceration of his left lower infraorbital (the area located below the eye and lateral to the nose) area and an abrasion to his left forehead. He was treated in the ER and transferred back to the facility the same day.

Immediate Jeopardy began on 03/13/2021 when the facility failed to prevent a cognitively impaired resident with known wandering and exit seeking behaviors from exiting the A hall through an alarmed exit door and eloping from the facility unsupervised. The Immediate Jeopardy was removed on 05/07/2021 when the facility provided and implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) to complete education and ensure monitoring systems put into place are effective related to supervision to prevent accidents.

The findings included:

Resident #167 was admitted to the facility on 03/11/2021 to the quarantine hall (A hall) with diagnoses which included history of falling, difficulty walking and vascular dementia.

Review of Resident #167's physician orders revealed an order for Eliquis (which is a drug used to treat and prevent blood clots) tablet 5 milligrams (mg) orally twice a day at 8:00AM and 8:00PM effective 03/11/2021.

There was no Minimum Data Set (MDS) on file but his admission nursing assessment completed

place were every 15 minute checks on the resident for 48 hours, alerted staff of resident's risk for elopement, involve resident in activities of resident's choice/interest, notify MD and RP if agitated or wandering behaviors increase, redirect as necessary, approach resident from front and speak in calm reassuring tone, and staff to monitor resident on a regular basis to determine whereabouts of resident.

Residents with the potential to be affected

All residents were reviewed by the Director of Nursing to include interviews with nurses and CNA regarding exit seeking behaviors, both verbal and physically attempting to exit the facility. The DON reviewed all progress notes for documentation of these exit seeking behaviors. No additional residents were identified as exhibiting exit seeking behaviors on 3/13/2021.

An audit was completed by the Administrator and Director of Nursing on 5/06/2021 of all residents to check for the following items: Is the resident an elopement risk; Does the resident display behaviors that place them at risk for elopement; is there a wanderguard in place and has an order been written for the wanderguard and to check for placement and functioning every shift; is a photo in the elopement risk book and is the elopement risk care plan in place, is wanderer on the resident banner. There were no additional residents identified as

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F 689	Continued From page 60 on 03/11/2021 revealed he was alert to person and situation but not time and was moderately cognitively impaired. The admission assessment also revealed he was independent with ambulation but required assistance of 1 staff member with dressing, toileting, personal and oral hygiene, and bathing. Review of a Psychosocial well-being elopement risk assessment completed on 03/12/2021 by the Corporate Nurse Consultant revealed the resident was a short-term rehab resident requiring dialysis three times weekly, moderately cognitively impaired, independent for walking in room and corridor, and independent for walking on and off the unit. Contributing factors for being at risk of elopement were recorded as verbalizing statements about leaving and wandering in and out of other resident rooms, recent move to the facility, diagnoses of dementia and reported from hospital that he had increased confusion at night. Interventions were recorded as pharmacist drug review, physical therapy, physician/Nurse Practitioner (NP)/Physician Assistant (PA) update, reality orientation, redirection, and social services. Outcome was recorded as interventions being somewhat effective. The evaluation was recorded as based on the risk assessment the resident presented an elopement risk and preventive actions to be taken were clothing labeled with identification, and door on A hall alarmed and functioning. Referrals that may be appropriate were recorded as psychotherapy. Plan of care was initiated on 03/12/2021. An interview on 05/17/2021 at 8:30AM with the Corporate Nurse Consultant (CNC) revealed she had been at the facility on 03/12/2021 and completed the elopement risk assessment. She	F 689	having been affected by the alleged deficient practice. System changes All facility staff were inserviced regarding elopement procedures by utilizing Peak Resources - Elopement Procedures Lesson plan dated 3/13/2021. This plan was initiated on 3/13/2021 and education was completed by 3/16/2021 by the Administrator, Corporate Nurse Manager and/or the Staff Development Coordinator. The education included: All residents will be assessed for elopement risk upon admission. If assessed as a risk the following will be done: A) Photo of resident placed in book at the front desk with the resident face sheet B) A wander guard will be placed on the resident C) A care plan will be initiated for At Risk for Elopement " Should an employee observe a resident leaving the premises, he/she should attempt to prevent the departure, obtain assistance from other staff members, as necessary. " Actual Elopement: Announce Code Find. " Conduct an initial search of the facility and grounds to confirm that the resident is missing. " Check every resident room, bathroom, closet, locked doors, office spaces, break rooms, parking lot, and cars. " Investigate other explanations for the	

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F 689	Continued From page 61 stated the interventions put into place were the interventions included in his care plan. The CNC further stated she could not recall if she had discussed the resident's wandering behaviors and risk for elopement with the nurses but said he had the wanderer banner on his face sheet which the nurse's could see when they pulled up his profile in the computer system. She indicated his picture was not in the elopement book at the nurse's station until after his elopement and stated she was not sure why that had not been placed in the book. According to the CNC the resident was on a hall where the door alarm was working on the day of her assessment and the staff was monitoring him every 15 minutes to determine his whereabouts. She explained the interventions in place should have prevented the resident's elopement; however, given the issue with the door not being alarmed correctly, the resident was able to get out of the building. Review of Resident #167's care plan dated 03/12/2021 revealed the resident was at risk for elopement from the facility related to cognitive impairment, poor decision making, new admission as evidenced by aimless wandering/exit seeking and statements suggesting he was going home. The goal was for the risk of elopement to be minimized over the next review date of 06/13/2021. The interventions included alert staff of resident's risk for elopement, involve resident in activities of resident's choice/liking by offering diversions such as food, TV, conversation, puzzles, magazines, etc., notify Medical Doctor (MD) and Responsible Party (RP) if agitation, wandering behaviors increase, redirect as necessary, approach resident from the front and speak in calm reassuring tone, staff to monitor resident on a	F 689	resident's absence, e.g., doctor's appointment, leave of absence, sign out book, room transfer, unplanned discharge, etc. Resident's last seen place, time and by whom. " Notify the Administrator, Director of Nursing, Resident representative, Attending Physician, Corporate Management Team, and local law enforcement authorities, as necessary. " The DON/Administrator will report to the state agencies, as appropriate. " Provide search team with identifying information: clothing last worn, photographs on file, any identifying features or body marks. " Provide search team with any known places or "haunts" that resident may frequent. " Determine cause of absence, such as emotional upset or system failure (unsecured exit doors, electronic device, or alarm failure). " Once resident is found, assess resident for any injuries (head to toe.) Egress door alarms on resident halls A, B, C, and D were changed on 03/13/2021 by the Maintenance Director and he changed the alarm to one that did not require key position to re-set the alarm but does require the key to turn the alarm off. The alarm worked essentially the same way except the new alarm automatically reengaged when the key was placed in to tum the alarm off. All facility staff educated by the Staff Development Coordinator (SDC) and/or Director of Nursing (DON) on door alarm	

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F 689	Continued From page 62 regular basis and know resident's whereabouts. Review of Resident #167's nursing progress notes revealed the following: Note written by Nurse #12 stated: "03/11/2021 at 7:29PM Behavior: Resident exit seeking stated he needed to go home resident redirected to his room explained to him why he is here." Additional note written by Nurse #12 stated: "03/11/2021 at 10:00PM Behavior: Resident walking in other residents' rooms resident taken back to his room." An interview on 05/03/2021 at 4:16PM with Nurse #12 revealed she had taken care of the resident on the evening of his admission on 03/11/2021 and stated he was confused and was able to ambulate on his own without assistance from staff or equipment. She informed the resident was wandering in and out of other resident rooms and was requiring redirection and assistance back to his room. Nurse #12 said she had reported the resident's wandering to the nurse on night shift. A note written by Nurse #13 stated: "03/12/2021 at 11:00AM Nursing: alert to name, confused wandering in and out of other resident rooms. Requires constant cues and reminding from staff to stop roaming and tearing up other resident's beds. Resident has been requesting to go home. Assisted by staff for redirection." An interview on 05/04/2021 at 11:22AM with Nurse #13 revealed Resident #167 was a wanderer but if she sat the resident in the hall with staff he would calm down and sit and talk.	F 689	procedures and the requirement to go to the door that is alarming to ensure that no one has exited the facility. This was completed by the DON and SDC by 5/7/2021. Any facility staff out on leave or on PRN status will be educated prior to returning to duty by the Director of Nursing and/or Staff Development Coordinator. Any newly hired licensed nurse will be educated during orientation by the Staff Development Coordinator. The Maintenance Director was educated by the Administrator on 5/6/2021 regarding checking all door alarms for proper functioning weekly. All licensed nursing staff were reeducated on elopement procedures as follows: all residents will have an elopement assessment completed upon admission, quarterly and with any significant change in condition, or new wandering/exit seeking behaviors, both verbal and physical. Any resident identified at risk for elopement will have their picture and face sheet placed in the elopement book at the nursing station. In addition, the resident banner on the face sheet in the electronic health record will have wanderer displayed on the banner. A wanderguard will be placed on the resident. An MD order for the wanderguard placement will be documented and an MD order to check for placement and functioning every shift will also be documented. This was be completed by the DON and SDC by 5/7/2021. Any facility staff out on leave or on PRN status will be educated prior to returning to duty by the Director of	

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Nurse #13 stated he would also calm if he could talk with his wife on the telephone. She explained there were indications in his record that he could get out of the facility if he really wanted to get out. According to Nurse #13 the indications were his exit seeking behaviors, his ability to ambulate independently in the hallway and his comments he wanted to go home. Nurse #13 indicated he was able to ambulate independently but probably should have used a walker for stability when ambulating. She disclosed she was not sure why he had not had a wander guard placed on him but stated he probably should have had one placed before he eloped. Nurse #13 reported there were always wander guards available for use in the medication carts.

A note written by Nurse #8 stated: "03/14/2021 at 12:25PM Behavior note recorded as late entry on 03/14/21 12:30PM Behavior: On 03/13/2021 the resident had attempted to exit from A hall door x 1 at approximately 8:15AM. Resident redirected, resident had breakfast and lunch, continued to make attempts to leave through the A hall door. Resident last observed at 2:45PM by Nurse Aide (NA) #6 in his room. At 3:15PM during rounds, resident was not in his room or on the hall. Staff initiated search, resident was not in the building, supervisor contacted 911 for assistance in searching."

An interview on 05/02/2021 at 3:55PM with Nurse #8 revealed she had been assigned to Resident #167 on 03/13/2021 for the 7:00AM to 7:00PM on the day of his elopement. Nurse #8 stated she was assigned to the A hall and the C hall and had 29 residents for which she provided medications and treatments. She reported Resident #167 had tried to get out the A hall door at 8:15AM and had

Nursing and/or Staff Development Coordinator. Any newly hired licensed nurse will be educated during orientation by the Staff Development Coordinator.

All staff were educated by the SDC, DON and RN supervisor on the importance of supervising residents and ensuring that residents are safe while in the facility. The inservice was titled: Elopement Risk/Communication/Interventions. Key points included definition of elopement, potential elopement hazards, prevention, interventions, communication, response, and documentation. This was completed by 5/7/2021. Any licensed nurse, medication aide and/or Certified Nursing Assistant out on leave or on PRN status will be educated prior to returning to duty by the Director of Nursing and/or Staff Development Coordinator. Any newly hired licensed nurse will be educated during orientation by the Staff Development Coordinator.

Monitoring:

An audit tool was developed to monitor all residents to check for the following items: Is the resident an elopement risk; Does the resident display behaviors that place them at risk for elopement; is there a wanderguard in place and has an order been written for the wanderguard and to check for placement and functioning every shift; is a photo in the elopement risk book and is the elopement risk care plan in place, is wanderer on the resident banner. Director of nursing or Administrator will

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F 689	Continued From page 64 set off the alarm. Nurse #8 indicated she had reset the alarm that morning. She disclosed Resident #167 tried several times that morning to get out and she had reset the alarm and redirected him back to his room. Nurse #8 mentioned they were doing frequent checks on him (looking in on him every 15 minutes to make sure they knew where he was) because they did not have enough staff to sit with him 1 on 1 and said she had gone to the C hall to complete her treatments. She stated NA #6 was on the A hall providing care to residents while she went to the C hall. Nurse #8 said NA #6 last saw the resident around 2:45PM and went to provide care to 2 other residents. She indicated when NA #6 went to check on Resident #167 at 3:15PM he was not in his room. Nurse #8 further indicated NA #6 notified her Resident #167 was not in the room and told her she had not heard the alarm go off, so they began searching for the resident and notified the supervisor the resident was not in his room. She stated they searched the building and could not find the resident so the supervisor called the police, notified the resident's responsible party (RP), notified the Medical Director and called in ancillary staff to aid in the search for the resident. Nurse #8 further stated the supervisor also called the Director of Nursing (DON) at the time who also came in to aid in the search for the resident. According to Nurse #8 she must not have reset the alarm correctly since NA #6 had not heard the alarm go off. She reported Resident #167 had tried a couple of times that day to get out the A hall entrance door and stated she had reset the alarm after his last attempt while he was standing next to her still trying to get out and said she apparently had reset it incorrectly and had actually turned the alarm off or either it malfunctioned. Nurse #8	F 689	audit 25% of residents x 4 weeks; then 10% for 8 weeks; then ongoing will be determined by 3 months of the audit findings. Quality Assurance Performance Improvement Director of Nursing or Administrator will bring the results of the audits to the Quality Assurance and Performance Improvement Committee for further review and recommendation. Completion date June 7, 2021.	

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indicated the alarm had gone off a couple of times that day from the resident trying to get out the door but stated they had not heard the alarm when he got out of the building. She further indicated they had tried to look in on him frequently and stated she probably should have put a wander guard on him after his first attempt to get out the door and stated she did not know why she had not put one on him. Nurse #8 advised the supervisor was aware Resident #167 had tried multiple times to get out but stated he was working on a cart that day and was busy caring for his own residents. She disclosed staff on A hall had used that entrance when going out and each time she had to turn the alarm off with her key. According to Nurse #8 each nurse on each hall had the key to the door at the end of their hallway on their set of keys and if their door alarms, they must turn the alarm off with their key. She stated she had turned the alarm off several times that day because of the resident and staff utilizing the door and must not have alarmed it correctly the last time she turned the alarm off. Nurse #8 reported she knew the alarm was working earlier in the day because it had gone off a couple of times. She indicated she could not remember if she checked the alarm or not after Resident #167 was missing because she was searching for the resident and trying to take care of her other assigned residents.

A follow up telephone interview on 05/04/2021 at 3:44PM with Nurse #8 revealed she still was not sure what happened with the exit door alarm on 03/13/21 but stated she nor NA #6 had heard the alarm go off when Resident #167 left the building unattended. She explained the only thing she could think was she had incorrectly reset the alarm after his first attempt to get out that day.

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Nurse #8 disclosed she had not thought about putting a wander guard on him that day but stated she probably should have done that after his first attempt to get out. She indicated if she had put the wander guard on maybe NA #6 would have heard the alarm go off and redirected the resident back to his room before he was able to get out the door. Nurse #8 stated the wander guards were available and kept on the medication carts and reported there were wander guards available for use that morning. Nurse #8 advised she was not sure she could have heard the door alarm on the C hall when she was down there doing treatments but stated NA #6 would have been able to hear the alarm.

An interview on 05/02/2021 at 3:40PM with NA #6 revealed she had been assigned to Resident #167 on 03/13/2021. She stated he was agitated that day and wanted to go home and made a couple of attempts to get out of the A hall door and had set the alarm off a couple of times that morning. NA#6 indicated she had last laid eyes on the resident around 2:45PM and he was laying in his bed resting. She mentioned she went to provide incontinence care to 2 other residents on the floor and by the time she finished and checked on Resident #167 he was not in his room. She explained she looked in all the rooms on the A hall for him and when she couldn't find him, notified Nurse #8 (who was on the C hall) she couldn't find Resident #167. According to NA #6 everyone stopped what they were doing and searched the building for the resident but stated they had not found him in the building. NA #6 stated they began searching the premises outside for him when they couldn't locate him in the building. She further stated she had not heard the alarm go off on the A hall while she was

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providing care to other residents.

An interview on 05/05/2021 at 11:37AM with the Rescue Squad representative revealed he had received a call on 03/13/2021 from a passerby that a gentleman, later found to be Resident #167, had fallen and was leaned up against a box at a local bakery (which was approximately a mile from the facility). The representative stated they had picked up Resident #167 at the local bakery and transported him to the local hospital ER since he had fallen and hit his head and had bruising and abrasions to his head and hand. He disclosed the resident was dressed in long sleeve shirt, pants, ball cap and shoes and was alert and able to identify himself to the rescue squad personnel and the hospital personnel.

Review of an incident/investigation report # 2021-001091 filed by the local police department and dated 03/13/2021 revealed the police department had been called and responded to a missing person alert on 03/13/2021 at 3:45PM. A policeman and detective responded, and their report read in part: "responded to facility in reference to a missing adult male (Resident #167). Spoke with the DON who stated the resident was last in his room at approximately 2:30PM and when the nurse (NA #6) checked on him at 3:15PM the resident was missing. The DON stated no alarm had sounded on any of the doors that alerts to anyone leaving the building. The facility does have surveillance cameras but at the time of this report there was no one that could view the camera footage to see when Resident #167 left the building. The staff stated they had checked the inside of the building to locate the resident; however, the resident was not located inside the building. Resident #167 will be

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entered NCIC (National Crime Information Center)." Review of a case supplement report dated 03/13/2021 at 5:36PM revealed the following: "Resident #167 was located at the local hospital emergency department (ED). The resident was not injured but had fallen and brought to the ED to get help. He is going to be discharged within an hour or so of me talking to him. Case closed and resident will be removed from NCIC.

The route Resident #167 took to the bakery required him to cross an intersection with a 4-lane road and then cross another intersection with a 2-lane road.

According to Weather.com the weather conditions in Shelby, North Carolina on 03/13/2021 from 2:40PM to 4:15PM was sunny and 78 degrees Fahrenheit (F).

Review of a hospital ER report revealed Resident #167 arrived at the local hospital ER at 4:16PM via rescue squad. He presented to the ER as status post fall. The note by the ER physician read: "Patient was walking when he tripped on a hole in the sidewalk and fell striking his head. Sustained an abrasion to left forehead. No loss of consciousness but does take Eliquis. Moderate intensity sudden onset mild left frontal headache. Non-radiating. No vomiting. No numbness tingling. No other modifying factors or associated symptoms, no other provocative or palliative factors." CT (computerized tomography) of head impression: no acute intracranial hemorrhage is identified. CT scan of Cervical spine impression: No acute displaced fracture is identified. If clinical concern and/or patient's symptoms persist, also consider

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correlation with MRI. Additional findings described above also present on prior exam. The resident was discharged from the hospital ER at 7:27PM and returned via EMS to the facility.

A note written by Nurse #2 stated: "03/13/2021 at 7:53PM Nursing: resident arrived back at facility via EMS, no acute distress noted. Wander guard applied to right ankle, call bell in reach.

An additional note written by Nurse #2 stated: "03/13/2021 at 9:35PM Nursing: Return to facility/post elopement: Resident returned to facility via stretcher at 7:45PM. Wander guard applied to right ankle. Alert and confused but responsive to verbal and tactile stimuli. Vitals: Blood pressure of 118/74, Pulse of 78, Respirations of 18 and temperature of 97.2. Assisted to bed with 2-person assist. Neuro checks initiated. Currently lying in bed with head of bed (HOB) slightly elevated, call light intact. Refuses full body assessment x 2 attempts (agitated and stated he would leave if keep messing with him)." Every 15 minutes visual checks initiated. Discolored bruising noted to left eyebrow. Area measures 2 centimeters (cm) by 2 cm with skin intact. Discolored bruising noted on left had. Area measures approximately 2 cm by 4 cm, skin intact. Discolored bruising noted to right hand, skin intact and measures 1 cm by 3 cm. Respirations are even and unlabored. No complaints of pain or discomfort voiced at this time. Tolerated by mouth medications without difficulty. Will continue to monitor. MD/family member notified. No attempts made to exit room/facility at this time."

An interview on 05/02/2021 at 11:04PM with Nurse #2 revealed she was working and assigned

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to Resident #167 when he returned from the Emergency Room (ER) on 03/13/2021 sometime around 7:45PM. Nurse #2 reported she had placed a wander guard on the resident upon his return to the facility. Nurse #2 stated she had gotten report from Nurse #8 at change of shift and had been told Resident #167 had exited the building earlier in the day through the A hall door. She explained once the wander guard was placed the resident received every 15-minute checks to ensure his whereabouts and the wander guard was on.

Review of a Post Elopement Report completed by Nurse #8 on 03/14/2021 for an elopement on 03/13/2021 revealed the following: "Resident #167 attempted to exit A hall door at 8:15AM on 03/13/2021 and was redirected, observed throughout the morning. At 2:00PM resident was seen in the hall in his wheelchair, at approximately 3:15PM, resident could not be located in the facility. Event details: When and where was resident found? In ER at 4:15PM. Did resident sustain any injury during elopement period? If so, describe: Resident had 2 abrasions on face. Did resident exhibit any of the following behaviors prior to elopement? Anger regarding facility placement, combativeness, elopement attempts in past - unsuccessful, repeatedly opening door/setting off alarms of secured doors, resisting redirection from staff, verbalizing statements about leaving, and wandering with no rational purpose and attempting to open doors. Mental status: Does resident exhibit any of the following as a change in mental status of new onset? Agitation, anxiety, confusion, and restlessness. Possible contributing factors: Are any of the following factors present? Dementia, and ESRD (end stage renal disease).

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Interventions - Immediate measures taken: Personal alarm - i.e., motion detector, photograph posted, and hall door alarm functioning. Outcome of interventions: Interventions effective - resident on 15-minute monitoring. Notification guidelines: Notify MD/NP/PA immediately for appropriate interventions. Notifications: Supervisor contacted physician on 03/13/2021 at 9:17PM, Supervisor notified family member on 03/13/2021 at 3:50PM and wander guard placed 03/13/2021 upon return to facility." The report remains open.

An interview on 05/03/2021 at 9:40AM with the Director of Nursing (DON) who was the weekend supervisor on 03/13/21, revealed he was not assigned to the resident, but the resident was assigned to Nurse #8. He said he had heard the alarm go off on the A hall a couple of times and was aware Resident #167 had attempted to leave the building but said he had not turned the alarm off because Nurse #8 had the keys to the A hall door. The DON disclosed Nurse #8 had notified him that she could not find the resident on rounds at 3:15PM. He stated Nurse Aide (NA) #6 had last seen Resident #167 at 2:45PM and then provided care to 2 other residents before getting back to check on him at 3:15PM. The DON advised he had notified the MD, the resident's RP, and the police when they could not locate Resident #167 in the facility. He indicated he had additionally contacted the former DON to let her know the resident had eloped. The DON explained he called in ancillary staff including the Regional Maintenance Director and Housekeeping Supervisor to assist in locating the resident. According to the DON when the police arrived, he gave a description of the resident but did not have a photo of the resident to share with

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the police. The DON stated once the former DON arrived, she took over the investigation and he went back to resident care on his hall.

An interview on 05/03/2021 at 2:22PM with the former Director of Nursing (DON) revealed she was at home when she got a call from the weekend supervisor on 03/13/2021 that Resident #167 had eloped from the building. She stated she went to the facility and notified the Administrator and the regional nurse consultant of the elopement. The former DON explained she had instructed the weekend supervisor to get statements from the staff and start a timeline of the elopement. She indicated when she got there the police were already there and there was no picture in the resident's medical record to give to the police to aid in the search of the resident. The former DON advised she was unable to view the security footage and was waiting on the Regional Maintenance Director to arrive to assist with the footage. She stated the police left with a description and began a search for the resident. The former DON disclosed when the Regional Maintenance Director arrived at the facility, he tested the A hall door and it was alarmed and functioning. She explained the Regional Maintenance Director was able to review the footage with her from the security camera and they saw Resident #167 exit the building at 2:40PM through the A hall door and leave the premises at 2:50PM walking up the street in front of the facility. The former DON indicated staff had searched the premises and woods and creek around the facility and were unable to find the resident. She advised the family members of Resident #167 arrived at the facility around 4:15PM and stated sometime around 5:15PM she called the hospital and asked if they had a John

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Doe and they said no and then she asked if they had Resident #167 and they replied they did and he had been there approximately an hour. She indicated Resident #167 should have had a wander guard placed after his first attempt to get out of the building through the A hall door that morning. The former DON advised their 1 to 1 was not truly a 1 to 1 but was just frequent checks on the resident (every 15 minutes to determine whereabouts). According to the former DON, Resident #167 did not have a staff member or family member sitting with him while in his room except right after the elopement.

An interview on 05/04/2021 at 2:56PM with the Regional Maintenance Director revealed he was called on 03/13/2021 and told Resident #167 had eloped from the facility and was missing. He stated when he came into the facility around 3:00 or 3:30PM he immediately went to the A hall entrance door and checked the door and when he pushed it open the alarm sounded and was loud and piercing. The Regional Maintenance Director further said once he checked the alarm, he went out to aid in the search for the resident. He indicated the door alarm and the wander guard alarm were separate alarms. The Regional Maintenance Director further indicated the alarms are tested every week by the Maintenance Director at the facility. He mentioned he was not sure what had happened that day but said the alarm was working on Thursday 03/11/2021 during the weekly testing when the Maintenance Director tested it and it was working on Saturday 03/13/2021 when he arrived at the facility after the elopement. The Regional Maintenance Director explained if the nurse did not properly turn the key to the on position when resetting the alarm then it would not alarm when someone

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went out the door. He indicated at the time of the elopement the alarm on the door required you turn it off if alarming, close the door and then turn the key to the on position to reset the alarm. According to the Regional Maintenance Director, if you did not do all the steps the door would not be alarmed. He reported after the elopement he changed the lock on the door such that the door automatically reset to on once you put in the key to turn off the alarm. The Regional Maintenance Director was not sure what happened to the alarm the day of the elopement but stated it was alarmed and functioning when he got to the facility. He indicated when he reviewed the security footage there was no sound so he could not determine if the alarm sounded or not. The Regional Maintenance Director advised when he reviewed the footage, Resident #167 was dressed in pants, long sleeve shirt, and a baseball cap but stated he could not see if he had on shoes.

An interview on 05/04/2021 at 5:19PM with the Administrator revealed she remembered Resident #167 and his elopement from the facility. She stated she had been called that Saturday and came to the facility and she and the former DON were coordinating the investigation. The Administrator further disclosed if the staff knew prior to 03/13/2021, Resident #167 was an elopement risk they should have put a wander guard on him as their policy and procedure suggested. She indicated they had also discovered his picture had not been taken on his admission date of 03/11/2021 and stated it would have helped the police in their search for Resident #167 if his picture had been on file. The Administrator explained there had been some confusion on the part of the staff regarding who

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was supposed to take the picture and neither staff member had photographed the resident for his medical record. According to the Administrator they should have had his picture on file, and he should have had a wander guard placed prior to his elopement.

The Administrator was informed of Immediate Jeopardy on 05/06/2021 at 11:25AM.

The facility provided the following Credible Allegation of Compliance:

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

The facility failed to supervise a cognitively impaired resident with wandering behaviors who exited from the facility unsupervised.

Resident #167 was admitted to the facility on 03/11/2021 with diagnoses which included history of falling, difficulty walking and vascular dementia. The elopement assessment completed on 3/12/2021 identified Resident #167 at risk for elopement. Facility failed to follow policy and procedure by not placing wander guard on resident.

Per nursing documentation resident displayed exit seeking behaviors. On 03/11/2021 at 7:29 PM, nursing progress note stated that resident was exit seeking and stated he needed to go home. The resident was redirected to his room. The nurse explained to him why he was at the facility. On 03/12/2021 at 11:00 AM, nursing progress note stated that the resident was wandering in and out of other resident rooms,

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requires constant cues and reminding from staff to stop roaming and tearing up other resident's beds. Resident has been requesting to go home. Assisted by staff for redirection. 03/13/2021, nursing progress note stated that the resident had attempted to exit from A hall door x I. Resident redirected, resident had breakfast and lunch, continued to make attempts to leave through A hall door. Staff had been trained to advance interventions to prevent elopement, such as wander guard, 15- minute monitoring checks, and one to one monitoring.

Resident was last observed at 2:45 PM on 3/13/2021 by the nursing assistant in his room. At 3:15 PM, during rounds resident was not in his room or on the hall. Staff initiated search and could not locate the resident. The nurse supervisor contacted 911 for assistance in searching for Resident #167. The Director of Nursing (DON) called the local hospital Emergency Room around 5:15 PM and located Resident #167, two (2) hours and 35 minutes after he exited the facility. Per facility video surveillance, Resident #167 exited the facility through the A hall exit door on 3/13/21 at 2:40 PM and was off the premises of the facility by 2:50 PM. The Director of Nursing (DON) called the local hospital Emergency Room around 5:15 PM and located Resident #167, two (2) hours and 35 minutes after he exited the facility.

Hospital records dated 3/13/21 noted the resident sustained a small laceration in his lower left infraorbital region that was shallow and non-gaping. The resident also sustained an abrasion to the left forehead but had no loss of consciousness. Resident #167 complained of a moderate intensity of mild left frontal headache

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that did not radiate and had not resulted in any vomiting or other associated symptoms. The resident had a computerized tomography (CT) scan which was negative.

Resident #167 returned to the facility from the ER at the local hospital at approximately 7:53 PM and a wander guard was applied to his ankle by Nurse #2. Other interventions put into place were every 15 minute checks on the resident for 48 hours, alerted staff of resident's risk for elopement, involve resident in activities of resident's choice/interest, notify MD and RP if agitated or wandering behaviors increase, redirect as necessary, approach resident from front and speak in calm reassuring tone, and staff to monitor resident on a regular basis to determine whereabouts of resident.

#2 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.

All residents were reviewed by the Director of Nursing to include interviews with nurses and CNA regarding exit seeking behaviors, both verbal and physically attempting to exit the facility. The DON reviewed all progress notes for documentation of these exit seeking behaviors. No additional residents were identified as exhibiting exit seeking behaviors on 3/13/2021.

All facility staff were in-serviced regarding elopement procedures by utilizing Peak Resources - Elopement Procedures Lesson plan dated 3/13/2021. This plan was initiated on 3/13/2021 and education was completed by 3/16/2021 by the Administrator, Corporate Nurse

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Manager and/or the Staff Development Coordinator. The education included:
All residents will be assessed for elopement risk upon admission. If assessed as a risk the following will be done:

A) Photo of resident placed in book at the front desk with the resident face sheet
B) A wander guard will be placed on the resident

C) A care plan will be initiated for "At Risk for Elopement"

"Should an employee observe a resident leaving the premises, he/she should attempt to prevent the departure, obtain assistance from other staff members, as necessary.
"Actual Elopement: Announce "Code Find".
"Conduct an initial search of the facility and grounds to confirm that the resident is missing.
"Check every resident room, bathroom, closet, locked doors, office spaces, break rooms, parking lot, and cars.
"Investigate other explanations for the resident's absence, e.g., doctor's appointment, leave of absence, sign out book, room transfer, unplanned discharge, etc. Resident's last seen place, time and by whom.
"Notify the Administrator, Director of Nursing, Resident representative, Attending Physician, Corporate Management Team, and local law enforcement authorities, as necessary.
"The DON/Administrator will report to the state agencies, as appropriate.
"Provide search team with identifying information: clothing last worn, photographs on file, any identifying features or body marks.
"Provide search team with any known places or "haunts" that resident may frequent.

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"Determine cause of absence, such as emotional upset or system failure (unsecured exit doors, electronic device, or alarm failure).
"Once resident is found, assess resident for any injuries (head to toe.)

The SDC was responsible for tracking staff that had not initially received the education and provided the education to the employee prior to returning to duty. The SDC was notified of this responsibility on 3/13/2021 by the Administrator.

Egress door alarms on resident halls A, B, C, and D were changed on 03/13/2021 by the Maintenance Director and he changed the alarm to one that did not require key position to re-set the alarm but does require the key to turn the alarm off. The alarm worked essentially the same way except the new alarm automatically reengaged when the key was placed in to tum the alarm off.

An audit was completed by the Administrator and Director of Nursing on 5/06/2021 of all residents to check for the following items: Is the resident an elopement risk; Does the resident display behaviors that place them at risk for elopement; is there a wander guard in place and has an order been written for the wander guard and to check for placement and functioning every shift; is a photo in the elopement risk book and is the elopement risk care plan in place, is "wanderer" on the resident banner. There were no additional residents identified as having been affected by the alleged deficient practice.

All facility staff will be educated by the Staff Development Coordinator (SDC) and/or Director of Nursing (DON) on door alarm procedures and

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the requirement to go to the door that is alarming to ensure that no one has exited the facility. This will be completed by the DON and SDC by 5/7/2021. Any facility staff out on leave or on PRN status will be educated prior to returning to duty by the Director of Nursing and/or Staff Development Coordinator. Any newly hired licensed nurse will be educated during orientation by the Staff Development Coordinator. The SDC will be responsible for tracking any employee requiring training. The SDC was notified of this responsibility by the Administrator on 5/6/2021.

The Maintenance Director was educated by the Administrator on 5/6/2021 regarding checking all door alarms for proper functioning weekly.

All licensed nursing staff will be reeducated on elopement procedures as follows: all residents will have an elopement assessment completed upon admission, quarterly and with any significant change in condition, or new wandering/exit seeking behaviors, both verbal and physical. Any resident identified at risk for elopement will have their picture and face sheet placed in the elopement book at the nursing station. In addition, the resident banner on the face sheet in the electronic health record will have "wanderer" displayed on the banner. A wander guard will be placed on the resident. An MD order for the wander guard placement will be documented and an MD order to check for placement and functioning every shift will also be documented. This will be completed by the DON and SDC by 5/7/2021. Any facility staff out on leave or on PRN status will be educated prior to returning to duty by the Director of Nursing and/or Staff Development Coordinator. Any newly hired licensed nurse will be educated during orientation

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by the Staff Development Coordinator. The SDC will be responsible for tracking any employee requiring training. The SDC was notified of this responsibility by the Administrator on 5/6/2021.

All staff will be educated by the SDC, DON and RN supervisor on the importance of supervising residents and ensuring that residents are safe while in the facility. The in-service was titled: Elopement Risk/Communication/Interventions. Key points included definition of elopement, potential elopement hazards, prevention, interventions, communication, response, and documentation. This will be completed by 5/7/2021. Any licensed nurse, medication aide and/or Certified Nursing Assistant out on leave or on PRN status will be educated prior to returning to duty by the Director of Nursing and/or Staff Development Coordinator. Any newly hired licensed nurse will be educated during orientation by the Staff Development Coordinator. The SDC will be responsible for tracking any employee required to have this training. The SDC and DON were notified of this responsibility by the Administrator on 5/6/2021.

The Administrator and Director of Nursing will be responsible for oversight of this plan and ensure compliance with training.

TITLE OF THE PERSON RESPONSIBLE FOR IMPLEMENTING THE CREDIBLE ALLEGATION FOR IMMEDIATE JEOPARDY REMOVAL.

The Administrator and the Director of Nursing will be ultimately responsible to ensure the implementation of credible allegation to remove this alleged immediate jeopardy.

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PEAK RESOURCES - SHELBY	1101 NORTH MORGAN STREET SHELBY, NC 28150

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F 689	Continued From page 82 Immediate Jeopardy Removal Date: 5-07-2021. The facility's IJ removal date of 05/07/21 was verified on 05/14/2021 as evidenced by observations and interviews. Observations revealed there were 3 residents in the facility with wander guards on and 1 of the 3 residents' wander guard alarmed when she came too closely to the front door. Staff were observed responding to the alarm. The A hall alarmed door was opened, and the alarm sounded and a Nurse Aide (NA) responded within 30 seconds and walked outside to ensure no one had left the building. The Nurse for the A hall responded within 60 seconds with the key to shut the alarm off. Review of records revealed all residents present in the building on 05/06/2021 had a risk assessment for elopement completed. The 3 residents identified at risk had wander guards placed if not already placed, and documentation revealed the wander guards were monitored every shift for placement and function. An elopement book was at the nurse's station with the 3 residents' photo and face sheets in the book and a banner that described the resident as a wanderer. Staff interviews revealed receipt of training regarding wandering behaviors, exit seeking behaviors, wander guards and responding to door alarms and wander guard alarms. Staff reported residents with wander guards received frequent checks to determine their whereabouts. Review of the training records and signage sheets revealed staff members received education regarding resident elopement and what to do in case of an elopement and those interviewed were able to recite what they were trained to do in case of an elopement. All staff were informed they must complete education prior to their next scheduled workday.	F 689		

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F 689	Continued From page 83 All newly hired staff will be educated during their orientation process.	F 689		
F 725 SS=G	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews, the facility failed to provide sufficient nursing staff, resulting in missed showers for dependent residents, partial baths or	F 725	F 725 Resident affected:	6/7/21

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F 725	Continued From page 84 bed baths being provided instead of preferred showers, and incontinence care not being provided for 9 of 15 residents reviewed for staffing. The findings included: This tag is cross referred to: 1. F550: Resident Rights: Based on record review, resident, and staff interview's the facility failed to provide incontinence care for 3 of 3 residents sampled for incontinence (Resident #42, Resident #16 and Resident # 17). The residents expressed feelings of being upset, angry, embarrassed, unclean and uncomfortable. 2. F561: Self Determination: Based on observations, record reviews, staff and resident interviews, the facility failed to honor resident's preference and number of showers per week for 4 of 6 residents reviewed for choices. 3. F677: Activities of Daily Living for Dependent Residents: Based on observations, record review, resident and staff interviews, the facility failed to provide showers scheduled for dependent residents for 2 of 6 residents sampled for activities of daily living. On 05/02/2021 at 3:00PM an interview was conducted with Nurse #8. She stated she worked 7:00AM to 7:00PM on weekends and there was never enough help. Nurse #8 further stated they were dependent on Agency staff to fill the holes on weekends and they frequently called out and the staff was left with not enough help to take care of the residents. She indicated all the weekend staff was tired and were frequently	F 725	Residents # 42, #16, and #17 suffered no physical adverse effects related to the staffs alleged deficient practice but did express some emotional distress. Resident #42 and Resident #16 remain at the facility with no residual adverse effects. Resident #17 was discharged from the facility. Residents with the potential to be affected: To identify any resident with the potential to be affected by the alleged deficient practice, the Regional nurse conducted an interview with 12 residents on 5/28/21 concerning their care delivery and staffing. No complaints were noted. System Changes: The following corrective action has been taken to help enhance staffing i.e.: 2 Agencies have been contracted with, open positions offered a sign on bonus, advertising in local newspapers, on-line, Facebook and have ordered advertising signage for the property. All nursing staff will be educated regarding “Call-outs” and how it affects the residents in the facility and how it affects their peers. This was initiated by the Administrator and/or designee on 5/28/21. Education will continue through 6/2/21. Any nursing staff unavailable due to LOA, FMLA or other reason will be educated	

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F 725	Continued From page 85 asked to stay over to cover holes in the schedule. Nurse #8 further indicated the Nurse Aides (NAs) did not have time to complete all the showers and frequently had to give "bird baths" or bed baths instead of taking residents to the shower. According to Nurse #8, the NAs had not reported noted being able to complete incontinence care every 2 hours but said when they were short staffed there was no way they could do incontinence checks and care for every resident every 2 hours. On 05/02/2021 at 11:04PM an interview was conducted with Nurse #2. She stated she worked 7:00PM to 7:00AM on the weekends and stated she was "about dead" from work. Nurse #2 further stated they commonly worked on the weekends with 2 nurses and 3 NAs in the whole building at night and stated it was just too much for the staff. She indicated there was one NA that was slow that worked 2nd shift and she often did not complete incontinence rounds and when the 3rd shift NAs came in they would have to change 4-5 residents including their pads and bed sheets because they were so wet. On 05/04/2021 at 8:24AM an interview was conducted with NA #8. She stated staffing had been "rough at times." She indicated they frequently used Agency staff to fill in the open positions on the schedule but unfortunately, they called in and left staff short. NA #8 explained they frequently pulled her or the Restorative Aide to cover holes in the schedule on 1st shift. She indicated she and the Restorative Aide worked together to get the residents on Restorative seen and sometimes had to work over shift to get everything done. NA #8 reported they currently had 2 NAs on medical leave, and it would be helpful when they were able to return to work full	F 725	upon their return by the Staff Development Coordinator. Any newly hired staff will be educated during orientation by the Staff Development Coordinator. Monitoring: Monitoring to ensure that solutions are sustained will be performed by the Social Worker, Director of Nursing (DON) or Administrator by utilizing the “Resident Interview” form. Three (3) residents’ will be interviewed weekly for 4 weeks then 3 residents every other week for 8 weeks. Residents unable to be interviewed due to cognitive impairment will have resident family/representative answer the same interview questions. Random residents will be selected during the audits and will include all shifts, including weekends. Ongoing interviews will be determined by the results of the prior 3 months. The audit will consist of the following interview question: (1) Do you feel your needs are met such as toileting, showers, bed bath, etc… by the nursing staff? Quality Assurance Performance Improvement: The results of the audits will be brought to the Quality Assurance and Performance Improvement Committee monthly by the Director of Nursing.	

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F 725	Continued From page 86 time. On 05/05/2021 at 2:09PM an interview was conducted with the Scheduling Assistant (SA). She stated she was currently doing the schedule utilizing Agency staff and the facility staff. The SA further stated she used two different Agencies they were contracted with to fill the holes in the schedule. She indicated staff are frequently asked to stay over due to call ins with Agency staff. The SA explained she had Monday through Friday staff that worked 8 hours shifts and weekend staff that worked 12-hour shifts. She disclosed Monday through Friday on 1st shift she had 4 nurses, a treatment nurse and a charge nurse with no open nurse positions. She said if a nurse called in on 1st shift, she pulled the treatment nurse or the charge nurse to replace the call in. The SA indicated Monday through Friday she had 1 nurse on 2nd shift and relied on Agency staff to fill the holes or asked the facility staff to work over if Agency staff was not available. She reported there were currently 4 open Nurse positions on 2nd shift Monday through Friday. The SA stated Monday through Friday on 3rd shift she had 1 nurse and relied on Agency staff to fill the holes or asked facility staff to work over their shift. She advised there were 2 open nurse positions on 3rd shift. On weekends they work 12 hour shifts and she indicated they had 2 nurses that worked 7:00AM to 7:00PM and there were 3 open nurse positions on the weekend. She indicated they had 3 nurses that worked 7:00PM to 7:00AM and they had no 7:00PM to 7:00AM nurse positions. The SA stated they were staffed for NAs on Monday through Friday 1st shift and had 5 full time NAs. She revealed on Monday through Friday 2nd shift she had 3 NAs and there were 4 open positions.	F 725	Completion date June 7, 2021.	

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F 725	Continued From page 87	F 725		

On 3rd shift the SA explained there were 4 NAs but 1 was on medical leave and they had 1 float NA position open on 3rd shift. She reported on weekends there were 3 NAs on the 7:00AM to 7:00PM shift and 3 open NA positions. The SA stated on weekends there were 3 NAs on the 7:00PM to 7:00AM shift but one was on medical leave and there were 2 open positions for NAs on the 7:00PM to 7:00AM shift. According to the SA staffing the facility had been very challenging given the staff she currently had and all the open positions. She advised she currently had 9 open nurse positions and 11 open NA positions, and it had been difficult to recruit staff due to the area hospital and other nursing homes in the area.

On 05/06/2021 at 4:52PM an interview was conducted with the Director of Nursing (DON). He revealed the facility had a challenged demographic and it had been difficult to recruit the caliber of nurse and NA he desired for the residents to have optimum health and care. The DON stated they were recruiting through agencies online and were offering sign on bonuses as well as bonuses to current staff working and filling the holes on the schedule. He explained he was working to develop a more professional environment and encouraging the staff to be more focused and work together professionally and move the facility in a more positive direction. The DON indicated their challenges with staffing were not insurmountable, but it had to be a collaborative effort among the staff. He further indicated they needed to admit appropriate residents to the facility based on the current skill set of the staff and said it was not logical to keep bringing difficult residents in the facility without the staff to care for them. According to the DON, he expected the residents

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F 725	Continued From page 88 to receive their showers as preferred, showers including getting their hair washed and incontinence care as needed. On 05/06/2021 at 6:00PM an interview was conducted with the Administrator. During the interview she admitted they had some challenges with staffing and were working with corporate to recruit staff for the open positions for nurses and NAs. The Administrator stated she expected the NAs to ask for assistance when they were not able to complete showers and provide incontinence care and stated there were ancillary staff working other positions who were NAs that could assist as needed with resident care. She disclosed she was not aware showers were not being provided based on resident preference and that incontinence rounds were not being provided every 2 hours and as needed. According to the Administrator, she expected the residents to receive their showers as preferred, including getting their hair washed and expected them to be provided incontinence care every 2 hours and as needed. She stated they had tried to relieve some of the work for their staff by using Agency staff but said it had been difficult when the Agency staff had called in or not shown up for their shift. The Administrator advised they were offering bonuses to their staff and were offering sign on bonuses for new hires.	F 725		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed	F 755		6/7/21

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F 755	Continued From page 89 personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interviews with staff and pharmacist, the facility failed to obtain blood pressure medications from the pharmacy for 1 of 5 residents (Resident #42) observed for medication administration. The findings included: Resident #42 was admitted to the facility on 7/8/19 with diagnoses that included hypertension.	F 755	F755 F755 Residents affected: Residents # 42 suffered no physical adverse effects related to the staffs alleged deficient practice. Resident #42 remains at the facility with no residual adverse effects.	

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F 755	Continued From page 90 The Physician's Orders in Resident #42's electronic medical record indicated active orders as of 5/4/21 for: *Diltiazem 120 mg (milligrams) 1 capsule by mouth once a day for hypertension *Metoprolol 50 mg 1 tablet by mouth twice a day for hypertension On 5/4/21 at 8:09 AM, Nurse #6 was observed as she prepared and administered Resident #42's medications. Nurse #6 searched for Resident #42's Diltiazem and Metoprolol medication cards in the C hall medication cart but could not find them. Nurse #6 proceeded to administer the rest of Resident #42's medications. On 5/4/21 at 8:24 AM, an interview with Nurse #6 revealed she did not know why Resident #42's Diltiazem and Metoprolol tablets were not available. Nurse #6 stated she would call the pharmacy and re-order both medications which should be delivered to the facility later in the day. Nurse #6 stated the nurse who worked the day before might have used the last ones and probably forgot to pull the stickers and re-order both medications. A second interview with Nurse #6 on 5/4/21 at 2:40 PM revealed the facility had stock medications kept in an automated dispensing system in the medication room. During the interview, Nurse #6 searched the system and found nine Metoprolol 25 mg tablets and three Diltiazem 120 mg capsules available. Nurse #6 stated she did not know that these medications were available in their automated dispensing system which was why she did not think of looking this morning. Nurse #6 added that she thought only narcotic medications were available	F 755	Other residents with the potential to be affected: All other residents in the facility have the potential to be affected. An audit was conducted on May 28, 2021 by licensed practical nurse comparing medication administration record (MAR) to the medications in the cart to ensure that all ordered medications were available and if not, had been ordered. It was determined that no additional residents were adversely affected by the alleged deficient practice. System Changes: One to one in-services were conducted with Nurse # 6 by the Director of Nursing on May 25, 2001 and Nurse # 2 by the Staff Development Coordinator on May 30, 2021 to ensure nurses are aware of the medication ordering process; the automated dispensing machine, and the backup pharmacy process. All licensed nurses and contracted licensed nurses will be educated by the Director of Nursing/designee on the medication ordering process, the automated dispensing machine (eMed machine) and the backup pharmacy process by June 7. Any licensed nursing staff out on leave or PRN status will be educated prior to returning to their assignment by the Staff Development Coordinator/designee.	

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F 755	Continued From page 91 in the automated dispensing system in the medication room. A third interview with Nurse #6 on 5/6/21 at 11:09 AM revealed they still had not received Resident #42's Diltiazem and Metoprolol tablets from the pharmacy. Nurse #6 disclosed that she had to pull the scheduled doses for Diltiazem and Metoprolol from the automated dispensing system in the medication room for the past two days. She stated that she did not call the pharmacy to follow-up on 5/5/21 after they did not deliver the ordered medications on 5/4/21. An interview with Nurse #7 on 5/6/21 at 5:25 PM revealed she had worked from 5/3/21 to 5/6/21 on the evening shift on B hall and had to pull Resident #42's Metoprolol doses from the automated dispensing system in the medication room. Nurse #7 stated she was sure she had re-ordered the medication, but she never called the pharmacy to find out why they had not dispensed Resident #42's Metoprolol. Nurse #7 disclosed they had been experiencing a lot of issues with the current pharmacy regarding medications not being delivered after they had ordered them. A phone interview with the pharmacist on 5/6/21 at 11:25 AM revealed they had last dispensed to the facility a 30-day supply of Diltiazem on 4/22/21 and a 30-day supply of Metoprolol on 4/6/21 for Resident #42. The pharmacist stated they were sending another 30-day supply of Metoprolol for Resident #42 with the routine delivery on 5/6/21. He added that he was not sure why the facility had run out of Resident #42's Diltiazem too soon and the order to refill this medication must have been rejected through the	F 755	Newly hired licensed nursing staff and any contracted nursing staff will be educated during orientation by the Staff Development Coordinator/designee. Monitoring: Audit tool was developed to ensure residents have their ordered medication in the medication cart or ensure that it has been ordered. The audit tool consists of the following: Does the resident have all of the ordered medications in the medication cart? If no to above, has the nurse made alternate arrangements to obtain the medication, i.e. used automated dispensing machine, asked the pharmacy to call the medication into backup pharmacy? The Director of Nursing, Staff Development Coordinator and/or designee will audit 10% of the residents in house weekly x 4 weeks, and then 10% every other week x 4 weeks, then monthly x 1 month. The need for further monitoring will be determined by the prior month of auditing. Quality Assurance Performance Improvement The Director of Nursing and/or Staff Development Coordinator will bring results to the Quality Assurance and Performance Improvement Committee for	

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F 755	Continued From page 92 insurance because it was too early to refill it. The pharmacist also stated he could send the facility extra doses of Diltiazem but would have to charge the facility for them. An interview with Nurse #8 on 5/2/21 at 3:10 PM revealed they had been experiencing some issues with getting the correct count of medications delivered by the current pharmacy. She remembered an instance within the last month when they delivered the wrong count of narcotics and she had to send them back because of the incorrect count. A phone interview with Nurse #2 on 5/4/21 at 10:54 AM revealed there were certain times within the last month when she was about to give a medication and it was not available. Nurse #2 stated it was sometimes hard to get into the automated dispensing system and she often got locked out and was unable to obtain the needed medications from it. Nurse #2 stated when this happened, she was unable to give the medication to the resident as ordered because it was not available. An interview with the Director of Nursing (DON) on 5/6/21 at 4:30 PM revealed when medications were not available, the nurses should call the pharmacy and the pharmacy should be able to send some through back-up if they were totally out of the medication. An interview with the Administrator on 5/6/21 at 5:40 PM revealed the nurses should follow-up with pharmacy if any medication was not available.	F 755	review and further recommendations. Completion date June 7, 2021.	
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More	F 759		6/7/21

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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 759	Continued From page 93 CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on record review, observations and interviews with staff and physician, the facility failed to maintain a medication error rate of less than 5% as evidenced by the omission of 3 medications out of 28 opportunities, resulting in a medication error rate of 10.71% for 2 of 5 residents (Residents #42 and #47) observed during medication administration. The findings included: 1. Resident #42 was admitted to the facility on 7/8/19 with diagnoses that included hypertension. The Physician's Orders in Resident #42's electronic medical record indicated active orders for Diltiazem 120 mg (milligrams) 1 capsule by mouth once a day and Metoprolol 50 mg 1 tablet by mouth twice a day. On 5/4/21 at 8:09 AM, Nurse #6 was observed as she prepared and administered Resident #42's medications. Nurse #6 searched for Resident #42's Diltiazem and Metoprolol medication cards in the C hall medication cart but could not find them. Nurse #6 proceeded to administer the rest of Resident #42's medications. On 5/4/21 at 8:24 AM, an interview with Nurse #6 revealed she did not know why Resident #42's	F 759	F759 Residents affected: Residents # 42 and Resident 47 suffered no physical adverse effects related to the staffs alleged deficient practice. Resident #42 and Resident #47 remains at the facility with no residual adverse effects. Other residents with the potential to be affected: All other residents in the facility have the potential to be affected. An audit was conducted on May 28, 2021 by licensed practical nurse comparing medication administration record (MAR) to the cart. It was determined that no residents were adversely affected by the alleged deficient practice. Facility administration compliance report was reviewed on May 28, 2021 no residents had any omissions of medications. System Changes: One to one education was provided to Nurse # 6 and Nurse # 4 by the Director of Nursing on May 27, 2021 concerning	

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F 759	Continued From page 94 Diltiazem and Metoprolol tablets were not available. Nurse #6 stated she would call the pharmacy and re-order both medications which should be delivered to the facility later in the day. Nurse #6 stated the nurse who worked the day before might have used the last ones and probably forgot to pull the stickers and re-order both medications. A follow-up interview with Nurse #6 on 5/4/21 at 2:40 PM revealed the facility had stock medications kept in an automated dispensing system in the medication room. During the interview, Nurse #6 searched the system and found nine Metoprolol 25 mg tablets and three Diltiazem 120 mg capsules available. Nurse #6 stated she did not know that these medications were available in their automated dispensing system which was why she did not think of looking this morning. Nurse #6 added that she thought only narcotic medications were available in the automated dispensing system in the medication room. An interview with the Director of Nursing (DON) on 5/6/21 at 4:30 PM revealed Nurse #6 should have checked the medication overflow when she did not see Resident #42's medication cards for Diltiazem and Metoprolol. If none was available, she should have checked the stock medications in their automated dispensing system. The DON stated Nurse #6 had informed him that she couldn't find Resident #42's Diltiazem and Metoprolol doses but he didn't know that Nurse #6 did not look in their stock medications until the afternoon. The DON stated he expected the nurses to check the rights (right resident, right drug, right dose, right route, and right time) of medication administration to prevent a medication	F 759	medication errors and medication ommissions, how to obtain medications from automated dispensing machine and/or backup pharmacy. A medication pass audit was completed by the Regional Nurse Manager on May 27, 2021 for Nurse #6 and Nurse #4 with a 0% medication rate. All nursing staff and any contracted nursing staff will be educated regarding medication administration, including how to obtain medications from automated dispensing machine and/or backup pharmacy. This will be completed by the Staff Development Coordinator and/or designee by June 7, 2021. This education will include the following: (1) The nurses will be able to administer medication properly and without error. (2) The nurses will understand how to utilize the E-Med machine to obtain medications not on the cart. (3) Nurses will understand the process of using the backup pharmacy. Any licensed nursing staff out on leave or PRN status will be educated prior to returning to their assignment by the Staff Development Coordinator/designee. Newly hired licensed nursing staff and any contracted nursing staff will be educated during orientation by the Staff Development Coordinator/designee. Monitoring:	

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F 759	Continued From page 95 error. A phone interview with the physician on 5/5/21 at 5:17 PM revealed he did think Resident #42 missing a single dose of her Diltiazem and Metoprolol brought any harm to her. The physician stated he had expected the nurses to give medications as ordered and give the appropriate dose at the right time. An interview with the Administrator on 5/6/21 at 5:40 PM revealed if medications were not available in the medication carts, the nurses should check the stock medications in the automated dispensing system in the medication room. 2. Resident #47 was admitted to the facility on 7/1/19 with diagnoses that included vitamin deficiency. The Physician's Orders in Resident #47's electronic medical record indicated an active order for Multivitamin with minerals 1 tablet by mouth once a day. On 5/4/21 at 9:05 AM, Nurse #4 was observed as she prepared and administered Resident #47's medications. Nurse #4 looked at Resident #47's electronic MAR (Medication Administration Record) and pulled the resident's medications off the medication cart. Nurse #4 administered 9 out of 10 medications that were due to be given at that time. Nurse #4 did not administer Resident #47's Multivitamin with minerals tablet. On 5/4/21 at 10:06 AM, an interview with Nurse #4 revealed she missed Resident #47's	F 759	Audit tool initiated on May 27, 2021 to manage medication administration. This audit will be conducted during medication administration. The audit consists of the following: (1) Nurse has administered the medication as ordered. (2) Do nurses know how to obtain medications from emed or obtain medications from backup pharmacy. Alert and oriented residents will be interviewed to determine if they received the medications as ordered. The Director of Nursing, Staff Development Coordinator and/or designee will audit 2 nurses per week on all shifts including weekends to include 10% of the residents medication administration pass weekly x 4 weeks and then 2 nurses to include 10% of residents every other week x 4 weeks, then 2 nurses monthly to include 10% of residents x 1 month. The audits will observe if the residents receive all of their medications as ordered and if the medication is not in the medication cart, that the nurse has attempted to retrieve from the automated dispensing machine and/or backup pharmacy. The need for further monitoring will be determined by the prior month of auditing. Quality Assurance Performance Improvement: The Director of Nursing and/or Staff	

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F 759	Continued From page 96 Multivitamin with minerals tablet. Nurse #4 explained that she did not scroll all the way down when she was checking Resident #47's MAR and did not see that she was supposed to give her Multivitamin with minerals tablet. An interview with the Director of Nursing (DON) on 5/6/21 at 4:30 PM revealed Nurse #4 should have read Resident #47's MAR more thoroughly when she was giving her medications. The DON stated he expected the nurses to check the rights (right resident, right drug, right dose, right route, and right time) of medication administration to prevent a medication error. A phone interview with the physician on 5/5/21 at 5:17 PM revealed he did think Resident #47 missing a single dose of her Multivitamin with minerals tablet brought any harm to her. The physician stated he had expected the nurses to give medications as ordered and give the appropriate dose at the right time. An interview with the Administrator on 5/6/21 at 5:40 PM revealed the nurses should double check the MAR before giving medications to the residents.	F 759	Development Coordinator will bring results to the Quality Assurance and Performance Improvement Committee for review and further recommendations. Completion date June 7, 2021.	
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761		6/7/21

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F 761	Continued From page 97 §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and interviews with staff and pharmacist, the facility failed to date opened medication vials, discard outdated medications, cover a medication bottle and separate topicals from oral medications in 1 of 1 medication room and 2 of 4 medication carts (D hall and C hall). The findings included: a. An observation of the medication room with Nurse #6 on 5/4/21 at 2:50 PM revealed an opened and undated vial of tuberculin purified protein derivative (PPD) in the medication room refrigerator. Half of the vial was left available for use. There was also a box of Preparation H suppositories labeled with Resident #47's name with an expiration date of October 2020. There were 5 suppositories left in the box available for use.	F 761	F761 Residents affected: Residents # 47 and Resident # 115 suffered no physical adverse effects related to the staffs alleged deficient practice. Resident #47 and Resident #115 remains at the facility with no residual adverse effects. Resident #39 not listed on the resident□s roster. Other residents with the potential to be affected: All other residents in the facility have the potential to be affected. An audit was conducted on May 7, 2021 by licensed practical nurses on all facility medication	

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F 761	Continued From page 98 An interview with Nurse #6 on 5/4/21 at 2:52 PM revealed she was not sure if the undated and opened vial of tuberculin PPD was still good to use. Nurse #6 shared that they used the tuberculin PPD to do a tuberculin skin test for new admissions and newly hired staff members, but she was unable to tell when it was last used or when it had been opened. Nurse #6 stated she thought it was acceptable to use if it was refrigerated but she did not know when it should be discarded after being opened. Nurse #6 confirmed that the Preparation H suppositories that belonged to Resident #47 were expired and should be discarded. An interview with the Clinical Coordinator (CC) on 5/4/21 at 3:00 PM revealed she was responsible for monitoring the temperature of the medication refrigerator but only occasionally checked the expiration dates of medications stored in the refrigerator. The CC admitted she had not checked the medications in the refrigerator and failed to notice that the tuberculin PPD had been opened and undated as well as the expired box of Preparation H suppositories for Resident #47. The CC stated the tuberculin PPD vial should have been dated whenever it was opened because it was only good for 30 days after being opened. The CC also stated that they should have discarded the Preparation H suppositories after they had expired. The CC added that Resident #47 had not received a Preparation H suppository recently because she did not have an active order for it currently. A phone interview with the pharmacist on 5/6/21 at 10:33 AM revealed they had dispensed 12 Preparation H suppositories for Resident #47 in April 2020 but did not have any record of when	F 761	carts and medication rooms to ensure that any opened medications in the medication cart and/or medication room were not expired; that any opened medication in the medication cart and/or medication room were dated with the date opened; that opened bottles in the medication carts and/or medication room are capped tightly; and that topical and oral medications are separated in the medication cart. It was determined that no other residents were adversely affected by the alleged deficient practice. System Changes: One to one education was provided to Nurse # 6 and Nurse # 9 by the Director of Nursing on May 27, 2021 concerning medication storage. This education included that any opened medications in the medication cart and/or medication room are not expired; any expired medications should be immediately disposed; that any opened medication in the medication cart and/or medication room are dated with the date opened; that any undated, opened medications in the medication cart and/or medication rooms are immediately disposed; and that topical and oral medications are separated in the medication cart. All licensed nursing staff and any contracted licensed nursing staff will be educated regarding proper storage of medications in medication carts and medication rooms. This will be completed by the Staff Development Coordinator	

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this medication was discontinued. The pharmacist stated the suppositories should have been discarded after the expiration date on the label which was October 2020.

b. An observation of the D hall medication cart with Nurse #9 on 5/6/21 at 10:43 AM revealed the following:

1. A bottle of Acidophilus probiotic blend was stored in the third drawer open to air without a lid. There were 20 capsules left inside the bottle available for use.
2. An opened bottle of Magnesium Citrate 10 fluid ounce with approximately ¾ of liquid still left in the bottle. It was dated as having been opened on 3/20/21.
3. An open Novolog flexpen labeled with Resident #46's name without a date when it had been opened.
4. A bottle of Nystatin powder labeled with Resident #51's name was stored in the third drawer along with the oral medications. Resident #51 did not reside in D hall.
5. A tube of Biofreeze labeled with Resident #10's name was stored in the third drawer along with the oral medications.

An interview with Nurse #9 on 5/6/21 at 10:45 AM revealed the lid on the Acidophilus probiotic blend bottle broke off and she did not think of discarding it and kept on storing it inside the medication cart. Nurse #9 did not know anything about the bottle of Magnesium Citrate, why it had been opened and for which resident it was given. She also did not know when Resident #46's Novolog flexpen had been opened but stated that it had been given to the resident last on 5/5/21 at 4:09 PM. Nurse #9 stated the Novolog flexpen

and/or designee by June 7, 2021. Any licensed nursing staff out on leave or PRN status will be educated prior to returning to their assignment by the Staff Development Coordinator/designee. Newly hired licensed nursing staff and any contracted nursing staff will be educated during orientation by the Staff Development Coordinator/designee.

Monitoring

An audit tool was developed and initiated on May 7, 2021 to monitor for compliance with medication storage. The audit tool consists of the following:
(1) Medication in the medication cart/medication room are not expired?
(2) All opened medications include date opened
(3) Topical and oral medications are separated on the medication cart
(4) Opened bottles are capped tightly
The Director of Nursing, Staff Development Coordinator and/or designee will audit 2 medication carts and the medication room weekly x 4 weeks, then biweekly x 4 weeks, and then monthly x1 month. The need for further monitoring will be determined by the prior month of auditing.

Quality Assurance Performance Improvement

The Director of Nursing and/or Staff Development Coordinator will bring results to the Quality Assurance and Performance Improvement Committee for

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F 761	Continued From page 100	F 761		

should have been dated when it was opened because it was only good for 28 days after opening. Nurse #9 also stated the Nystatin powder and the Biofreeze should be stored in the treatment cart and not on the medication cart along with the oral medications. Nurse #9 said she tried to check the medications in the D hall medication cart but did not always have time to go over each medication. She usually just paid attention to the medications that she gave to the residents.

c. An observation of the C hall medication cart with Nurse #6 on 5/6/21 at 11:05 AM revealed an opened and undated bottle of Latanoprost eye drops labeled with Resident #115's name. There was also another bottle of Latanoprost eye drops labeled with Resident #39's name and an open date of 2/18/21. Both eye drop bottles were labeled from the pharmacy as being good for 6 weeks after opening.

An interview with Nurse #6 on 5/6/21 at 11:09 AM revealed Resident #115's eye drop bottle should have been dated when it was opened. She asserted that Resident #115 had just transferred to C hall, so she was not sure who did not date it when they opened the bottle. Nurse #6 confirmed that Resident #39's eye drop bottle was expired and should have been discarded after 6 weeks of opening. Nurse #6 disclosed that Resident #39 last received her Latanoprost eye drops on 5/5/21 at 9:00 PM.

An interview with the Director of Nursing (DON) on 5/6/21 at 4:30 PM revealed that all medications in the medication room and the medication carts should be labeled and dated and discarded when no longer in use or expired. The

review and further recommendations.

Completion date June 7, 2021.

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F 761	Continued From page 101 DON stated any medication exposed to air or sunlight would affect its potency so the Acidophilus probiotic blend that was stored in the D hall medication cart should have been discarded when the lid broke off. He also stated the Magnesium Citrate bottle was a one-time use order and should have been discarded after 24 hours of opening. He also expected for the nurses to store all topicals in the treatment cart and all oral medications in the medication cart. The DON shared the third shift nurses were supposed to be checking the medication room every night and the medication carts at least once a week, but all nurses were responsible for checking the medication carts that they were using for unlabeled and expired medications. An interview with the Administrator on 5/6/21 at 5:40 PM revealed she expected the nurses to date medications when they were opened, discard expired medications, and keep treatments in the treatment cart and store them separately from oral medications in the medication carts.	F 761		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F 880		6/7/21

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and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed

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F 880	Continued From page 103 by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations and staff interviews, the facility failed to implement the Centers for Disease Control and Prevention (CDC) guidelines for the use of Personal Protective Equipment (PPE) when 4 of 4 staff members (Nurse #8, Nurse Aide (NA) #6, Certified Occupational Therapy Assistant (COTA) #1 and Housekeeper #1) failed to wear an N95 or higher respirator on the quarantine hall, failed to wear the N95 correctly, failed to have N95 masks and face shields available to staff on the hall, failed to perform hand hygiene while passing food trays room to room, failed to have Enhanced Droplet Contact Precautions signage on two of the seven resident doors, and failed to change their PPE between residents on the quarantine hall. These observations occurred during a global pandemic. The findings included: The Centers for Disease Control and Prevention (CDC) guidance entitled, "Preparing for	F 880	F880 Residents affected: No resident was adversely affected related to the staffs alleged deficient practice. Other residents with the potential to be affected: All residents on A, B, and C hall had the potential to be affected. No other resident suffered adverse effects as a result of the staffs alleged deficient practice. System Changes: The facility policies related to infection control precaution was reviewed by the administration on May 27, 2021 and no updates were needed. Education provided to Nurse #8, NA #6, Housekeeper #1, COTA #1, Nurse #1,	

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F 880	Continued From page 104 COVID-19 in Nursing Homes," updated on 11/20/2020 indicated the following statement under the section "Create a Plan for Managing New Admissions and Readmissions Whose COVID-19 Status is Unknown:" "Healthcare Personnel (HCP) should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a face shield that covers the front and sides of the face), gloves and gown when caring for these residents. The CDC guidance entitled, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic," updated on 02/23/2021 indicated the following statements under the section "Recommended infection prevention and control (IPC) practices when caring for a patient with suspected or confirmed SARS-CoV-2 infection:" "Disposable respirators should be removed and discarded after exiting the patient's room or care area and closing the door unless implementing extended use or reuse." "Put on eye protection (i.e., goggles or face shield that covers the front and sides of the face upon entry to the patient room or care area, if not already wearing as part of extended use strategies to optimize PPE supply." "Remove eye protection after leaving the patient room or care area unless implementing extended use." "Reusable eye protection (i.e., goggles) must be cleaned and disinfected according to manufacturer's reprocessing instructions prior to re-use. Disposable eye protection should be discarded after use unless following protocols for extended use or reuse."	F 880	and NA #1 by Staff Development Coordinator/Infection Control Preventionist Nurse by May 30, 2021. Education was related to Infection Control Precautions Policy and donning and doffing PPE to ensure employees adheres to policy when working the quarantine hall. All staff and contract employees will be educated on the Infection Control Precautions Policy and donning/doffing PPE. The education will be completed by Staff Development Coordinator/Infection Control Preventionist by June 7, 2021. Any staff on leave of absence or prn status will be educated prior to returning to their assignment. New employees will be educated during orientation by the Staff Development Coordinator/Infection Control Preventionist. Monitoring: PPE Audit Tool was developed to monitor compliance with PPE use, including the following: (1) Staff correctly identifies the appropriate PPE to use for the type of precautions ordered. (2) Staff observed donning all PPE correctly per CDC Guidelines. (3) Staff observed doffing all PPE correctly per CDC Guidelines. (4) Staff observed following transmission based on precaution guidelines correctly. (5) PPE supplies are located on the quarantine hall. (6) Staff performing hand hygiene while passing meal trays.	

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F 880	Continued From page 105 Review of the facility's policy entitled "Peak Resources Isolation/Quarantine Sites for COVID-19" revealed under the "Isolation Unit the following: 4. Environmental " Trained staff provided with necessary PPE 8. Therapy Services " Therapists will wear appropriate PPE while in the resident's room. 9. Personal Protective Equipment (PPE) " N95 surgical facemask and eye protection. " Remove PPE, perform hand hygiene when leaving the area. During an observation on 05/02/2021 at 9:15 AM of the A hall - which was the quarantine hall for new admissions and readmissions, there was no signage on the outside of the double doors leading onto the unit, and not all resident doors had posted signage for enhanced droplet contact precautions requiring mask, gown, gloves, face shield or goggles. There were 2 resident doors with no signage - rooms A4 and A9. At the time of the observation there were 7 residents on the quarantine hall. On 05/02/2021 during a continuous observation from 9:16AM to 10:16AM Nurse Aide (NA) #6 and Nurse #8 were observed entering rooms on the quarantine hall wearing a surgical mask instead of an N-95 mask and no face shield or goggles while providing care to residents on the quarantine hall, administering medications to residents in their room and providing care for the residents on the quarantine hall. Nurse #1 and NA #1 were observed without goggles or face shields going into resident rooms on the	F 880	Staff Development Coordinator/Infection Control Preventionist Nurse and/or designee will observe 25% staff weekly x 4 weeks, then every other week x 4 weeks, then monthly x 1 month. The need for further monitoring will be determined by the prior 3 months of auditing. Quality Assurance Performance Improvement Staff Development Coordinator/Infection Control Preventionist Nurse will bring results of all audits to Quality Assurance and Performance Improvement Committee for further review and recommendations. Completion Date June 7, 2021.	

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quarantine hall and failed to change their mask while going room to room and out of the quarantine hall. NA #6 was in room A4 caring for the resident with her mask down below her chin and then was observed leaving the quarantine hall at approximately 10:15AM and walking out to the nurse's station with the same surgical mask worn in resident rooms. Nurse #8 was observed wearing a disposable gown in the hallway of the quarantine hall and going room to room delivering medications from room to room during the observation and was wearing the same gown and surgical mask while going room to room. Housekeeper #1 was observed going into A1 with a surgical mask and gown on and cleaning the room and then walked across the hall with the same surgical mask and gown on and cleaned room A9. COTA #1 was observed in room A5 providing in room occupational therapy and was observed with a surgical mask on and gown. She came out of the room and went into room A1 with the same surgical mask and gown on to provide therapy. COTA #1 was then observed exiting room A1 and going to the next room with the same mask and gown on.

An interview on 05/02/2021 at 9:17AM with Housekeeper #1 revealed she had on a surgical mask while cleaning room A1. She stated she had been instructed to wear a surgical mask on the quarantine hall unless she was dealing directly with a resident. Housekeeper #1 further stated she was wearing the mask she had been told to wear on the quarantine hall but stated she had an N95 mask in her housekeeping cart.

An interview on 05/02/2021 at 10:17AM with COTA #1 revealed she had an N95 mask on under her surgical mask but had not had the

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straps of the N95 on her head because it was uncomfortable, so she wore the surgical mask over it. She stated she had not changed her gown between residents because she had been told she could wear the same gown from room to room and then discard it after the last resident on the hallway. She stated she was not wearing her goggles but should have been and stated there were no face shields available in the caddies or bins.

Another continuous observation of the quarantine hall on 05/02/2021 from 1:00PM to 1:20PM revealed the Dietary Aide brought the covered cart for the A hall to the double doors and NA #6 was moving the trays from the covered cart to an uncovered tray cart. Once she was finished the Dietary Aide took the covered cart back to the kitchen. NA #6 went into room A1 at 1:03PM dressed in mask, gown, face shield and gloves and delivered and help set up the resident's tray. She came out of the room after discarding her gloves in the trash inside the resident room and without sanitizing her hands put on a new pair of gloves and went into room A9 at 1:04PM and set up the resident's tray with the same gown, mask and face shield she had worn into room A1. She came out of room A9 sanitized her hands put on clean gloves and with the same mask and gown went into room A3 at 1:05PM and set up the resident's tray and came out and sanitized her hands and put on clean gloves and went into room A11 at 1:08PM with the same mask, gown and face shield on and set up the resident's tray and came out of room and changed her gown but not her mask and with the same face shield on that had not been cleaned between rooms went into room A4 at 1:11PM and set up the resident's tray and came out at 1:12PM sanitized her hands

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and put on new gloves but had on the same gown, mask and face shield that had not been cleaned and went into room A14 at 1:15PM to deliver and set up the resident's tray. NA #6 was observed coming out of A14, sanitized her hands and proceeded down the hallway and through the double doors with her same mask and face shield on, took her gown off at the double doors and proceeded through the double doors with the same mask and face shield on that had not been cleaned between rooms into the employee lounge to heat a resident's lunch.

An interview on 05/02/2021 at 3:00PM with Nurse #8 revealed she was assigned to take care of residents on the quarantine hall. She stated she usually wore her goggles the facility had supplied her but stated she had left them in her bag out in her car this morning. She further stated she had gone out to her car and got her goggles and put them on around 10:30AM. Nurse #8 indicated she was not sure why the other staff had not worn their goggles or a face shield but stated she had not asked them to put them on. She further indicated she had not had on an N95 this morning and was just wearing a surgical mask because that is what she had been instructed to do. Nurse #8 stated when she wore an N95 she had to wear a surgical mask over it to keep it in place because she didn't use the straps on the N95 because it did not fit her face and the surgical mask kept it in place. She further stated there were no surgical or N95 masks in the caddies or bins when she got to work this morning and stated she was not sure who stocked the caddies and bins. According to Nurse #8 she usually had to look for an N95 mask to wear on the weekends but stated surgical masks were readily available when she came to work. She further stated if she

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saw an employee with mask not covering their nose and mouth, she told them to pull it up over their nose and mouth.

An interview on 05/02/2021 at 3:20PM with NA #6 revealed she had not worn an N95 on the quarantine hall yesterday or this morning but had worn a surgical mask. She stated she had been told by Nurse #8 to put an N95 on and she had put it on around 10:30AM. NA #6 further stated she had not worn goggles or face shield yesterday while working on the quarantine hall and had not changed her mask yesterday between residents and had not changed her mask today between residents. She indicated no one had told her that she needed to change her mask between residents while working on the quarantine hall. NA #6 further indicated she had her mask pulled down below her chin in room A4 because she was wiping sweat from her face. According to NA #6 she had education on COVID-19, hand washing, wearing PPE on the quarantine hall and wearing a mask throughout the building.

An interview on 05/03/2021 at 4:11PM with the Infection Preventionist (IP) revealed if staff were working on the quarantine hall, they had to wear all PPE to include gown, gloves, N95 and goggles or face shield. She stated they had been instructed to wash and/or sanitize their hands and change their gowns between residents and change their N95 out daily or sooner if it gets soiled. The IP further stated they had a really good supply of PPE and had just gotten a large shipment of PPE from the coalition and had plenty of N95 masks, surgical masks, face shields, and gowns. She indicated the Central Supply Clerk ordered supplies on a regular basis

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and stated she did not know why the employees were not wearing N95s on the quarantine unit and stated they had been educated to wear all appropriate PPE and had been educated on how to wear PPE on the quarantine unit. She further indicated the facility had plenty of supplies for the staff.

An interview on 05/05/2021 at 9:48AM with the Central Supply Clerk (CSC) revealed the facility had plenty of Personal Protective Equipment (PPE). She stated the facility was currently well stocked with PPE supplies. The CSC further stated she was responsible for stocking the bins and caddies on the quarantine hall and stated they were fully stocked when she left work on Friday. She indicated she was not sure why they would have been out of supplies on Sunday unless someone was walking away with the supplies. The CSC further indicated they were not having to use any equipment with extended use and were not re-using anything except face shields which staff cleaned between residents.

An interview on 05/05/2021 at 1:47PM with the Director of Nursing revealed all staff had been educated and trained the A hall was the quarantine hall for the facility. He further revealed all staff had been educated to wash and/or sanitize their hands between residents, change their masks and gowns and clean their goggles or face shields when going room to room on the quarantine hall and should be wearing an N95 or KN95 mask on the quarantine hall. The DON stated all the residents on the quarantine hall should have signage on their door for Enhanced Droplet Contact Precautions and available PPE in a caddie on their door or a bin outside their door. He further stated the facility and all staff should

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F 880	Continued From page 111 be following the Centers for Disease Control and Prevention (CDC) and Centers for Medicare and Medicaid Services (CMS) guidelines for infection control and COVID-19. An interview on 05/06/2021 at 5:56PM with the Administrator revealed the staff should be changing their masks and gowns and cleaning their goggles or face shield when going in and out of resident rooms on enhanced droplet contact precautions on the quarantine hall. The Administrator stated the staff should be wearing an N95 or KN95 mask while caring for residents on the quarantine hall and had been educated on infection control principles and should know to change their masks and gowns between residents.	F 880		