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	345307	A. BUILDING _____ B. WING _____	C 07/14/2021

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E 001 SS=F	Establishment of the Emergency Program (EP) CFR(s): 483.73 §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.625, §485.727, §485.920, §486.360, §491.12 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.) *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The	E 001		8/16/21

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

Electronically Signed | 08/05/2021

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E 001	Continued From page 1 CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to develop and maintain a comprehensive emergency preparedness (EP) program which contained the required information to meet the health, safety, and security needs of residents and staff. This failure had the potential to affect all residents and staff. The findings included: 1. The facility's EP plan was reviewed on 7/14/20. This review revealed the facility did not develop and maintain an EP plan with the following required information: a. Development and maintenance of an EP program - The facility did not develop and maintain an EP plan that was reviewed and updated annually. b. Maintenance and annual EP updates - The facility did not maintain and update annually an EP plan based on a documented, facility-based, and community-based risk assessment utilizing an all-hazards approach, including missing residents. The facility did not maintain and update annually an EP plan that included strategies for addressing emergency events identified in the risk assessment. c. EP Program patient population - The facility did not maintain and update annually an EP plan that	E 001	Disclaimer: The Plan of Correction is not to be construed as an admission of any wrongdoing or liability. The facility reserves the right to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the facility reserves the rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of corrections should be considered as a waiver of any potentially applicable appeal review, quality assurance or self-critical examination privilege which the facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceedings. The facility offers I□s response, credible allegations of compliance and plan of correction as part of it□s ongoing efforts to provide quality care to residents. E001 Establishment of the Emergency Program	

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E 001	Continued From page 2 addressed resident population including, but not limited to, persons at-risk; the type of services the facility had the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. d. Process for EP collaboration - The facility did not maintain and update annually an EP plan that included a process for cooperation and collaboration with local, tribal, regional, State and Federal EP official's efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the Long Term Care (LTC) facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. e. Development of EP Policies and procedures - The facility did not maintain and update annually an EP plan that included EP policies developed and implemented based on an emergency plan identified via a facility-based and community-based risk assessment. f. Subsistence needs for staff and patients - The facility did not have a policy or procedure to address provision of pharmaceutical supplies in the event of evacuation or sheltering in place. g. Procedures for tracking of staff and residents - The facility did not develop a system to track the location of on-duty staff and sheltered patients in the LTC facility's care during an emergency. The LTC facility did not have a plan for documenting the specific name and location of receiving facilities or other locations. h. Policies and procedure including evacuation -	E 001	Residents Affected: No specific residents were identified as being affected by this practice. Residents Potentially Affected: Residents of the facility have the potential to be affected by this practice. Systemic Measures: The Regional Director of Maintenance Administrator will complete development of the Emergency Program according to the requirements set forth to meet the health, safety and security needs of residents and staff by Aug 21, 2021. Facility staff will be inserviced on the Emergency Plan and a copy will be made available at the Nurse□s Station. Monitoring Measures: The Emergency Plan will be reviewed at the Monthly QAPI Meeting by the QAPI Team monthly times 3 months, then quarterly thereafter. Once the quarterly reviews begin, the QAPI Team can determine the frequency of ongoing reviews. The Team at a minimum, consists of the Administrator, Director of Nursing, three other Department Managers and other team members as assigned or requested. Facility staff will be inserviced on emergency plan by 8/16/2021. Any staff that has not worked during that period of time will be inserviced prior to start of their shift. New hires will be inserviced during orientation.	

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E 001	Continued From page 3 The facility did not have a plan for safe evacuation from the LTC facility, which included consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. i. Policies and procedure for sheltering - The facility did not have a planned means for residents, staff, and volunteers to shelter in place in the facility. j. Policies and procedures for volunteers - The facility did not have a plan for use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. k. Arrangement with other facilities - The facility did not develop a plan with other LTC facilities and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. l. Roles under a waiver declared by Secretary - The facility did not have a plan for the provision of care and treatment at alternate care sites identified by emergency management officials. m. Development of communication plan - The facility had not developed, maintained, or updated annually an EP communication plan that was compliant with Federal, State, and local laws. n. Names and contact information - The facility	E 001	Compliance date 8/16/2021	

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E 001	Continued From page 4	E 001		

did not have a communication plan that included names and contact information for staff, resident's physicians, other LTC facilities, or volunteers.

o. Methods for sharing information - The facility did not develop a method for sharing medical documentation for residents under the care of the LTC facility or other healthcare providers for maintenance of continuity of care.

p. Sharing information on occupancy/needs - The facility did not have a means of providing information about the LTC facility's occupancy, needs, and ability to aid the authority having jurisdiction, the Incident Command Center, or designees.

q. Long Term Care and Intermediate Care Facilities/Individuals with Intellectual Disabilities Family Notifications - The facility did not have a method for sharing information from the emergency plan with residents and their families or representatives.

r. Emergency Prep training and testing - The facility did not develop, maintain, or annually review an EP training and testing program based on a risk assessment, policies, and procedures.

s. Emergency Prep training program- The facility did not develop or maintain an EP training and testing program.

t. LTC Emergency Power - The facility did not conduct required emergency generator inspection and testing.

u. Integrated Health Systems - The facility was

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part of a 9-facility healthcare system. The facility administration and regional maintenance director could not identify an EP system exercise.

A review of employee education and training revealed elopement in-services were provided on 5/5/21 and 6/29/21. Safety training was completed with new hires which included emergency management codes and procedures. The education contained a glossary of definitions (Color Code of emergencies) and how to activate an emergency plan. Instructions included "notify the administrator / designee or designated person in charge" for activation of "all hazards emergency plan."

An interview on 7/14/2021 at 4:15 PM with the Regional Maintenance Director revealed he had not conducted any EP exercises or reviews at the facility. He stated he reviewed the generator testing logs during survey and could not identify when the last 4-hour generator test was conducted. He stated the facility had been without a maintenance director for several months. He further stated the Emergency Preparedness Plan was his responsibility.

An interview on 7/14/2021 at 4:30 PM with the interim Administrator revealed he was ultimately responsible for the EP plan. He stated he had been in his role since June 2021 and had bigger issues to handle on his arrival. He disclosed the facility had a 3-day emergency supply of food and water. The Administrator further revealed he had looked in the EP book and saw a paper signed by the previous administrator with a date of March 2021. He only realized the plan had not actually been reviewed when surveyors asked to see the plan. He stated he should have checked the plan

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E 001	Continued From page 6 for the full review himself. The Administrator could not locate an "all hazards emergency plan." The Administrator acknowledged the missing sections of the plan and stated he and the Regional Maintenance Director would see to it that the plan was completed, and staff appropriately educated.	E 001		
F 000	INITIAL COMMENTS A recertification survey and complaint investigation survey was conducted on 7/12/21 through 7/14/21. A total of 2 allegations were investigated and both were unsubstantiated. Event ID# TH8U11.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly,	F 584		8/16/21

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F 584	Continued From page 7 and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, resident and staff interviews, the facility failed to maintain the air conditioning system to provide a comfortable room temperature for 2 of 2 residents (Resident #33 and Resident #30) reviewed for a safe, clean, comfortable, and homelike environment. The findings included: 1. Resident #33 was admitted to the facility on 6/11/21 with diagnoses that included chronic obstructive pulmonary disease, obstructive sleep apnea and seizure disorder. The Quarterly Minimum Data Set (MDS) assessment dated 7/5/21 indicated Resident #33 was cognitively intact.	F 584	F-584 Safe/Clean/Comfortable Environment Room changes were provided to Resident #30 on 7/28/21 and #33 on 7/26/21. All residents have the potential to be affected. A Maintenance Director from another building came and attempted to correct the HVAC system on 7/28/2021. On 8/5/2021 the corporate office contacted an outside contracted HVAC company who repaired the HVAC system and is currently operational. Temps were taken in residents rooms / hallways and all temps registered between 71 -73.9 degrees. Social	

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F 584	Continued From page 8 An interview with Resident #33 on 7/12/21 9:52 AM revealed she was disappointed at the facility because she felt it was falsely advertised when she was at the hospital. Resident #33 remembered looking at a brochure about the facility being newly renovated but when she was admitted, she noticed that there was no air conditioning inside her room. She stated air conditioning was only present in the hallways and in the common areas. Resident #33 stated she had to get her family member to bring her a portable electric fan just so she could get air in the room. Resident #33 further stated she needed her electric fan because she had difficulty breathing at night if she couldn't feel any air in her room. During the interview, an observation of Resident #33's room on 7/12/21 at 10:00 AM revealed no air was felt coming out from the vent inside the room. An interview with Nurse Aide (NA) #1 on 7/13/21 at 4:00 PM revealed she had worked with Resident #33 and that her room was warm, and Resident #33 had to keep her fan running all the time. An interview with Nurse #3 on 7/13/21 at 11:36 AM revealed she knew they had been working on the air conditioning system since the beginning of June but was aware that Resident #33 continued to have an issue with air not getting into her room. An interview with Nurse #1 on 7/14/21 at 6:57 AM revealed the lack of air conditioning had been an ongoing issue in some of the rooms on the hall where Resident #33 resided. Nurse #1 stated	F 584	services, Activities, Human resources, housekeeping manager, dietary manager, minimum data set nurse, staffing and rehab manager asked all resident if their room temperatures were comfortable and all were comfortable with no issues. Social Services and/or activity director will interview 1 resident from each hall regarding comfort temperature level in their individual rooms and throughout the facility two times per week for 4 weeks, then 1 time per week for 4 weeks. Maintenance Director will do temperature readings in random rooms, hallways and other resident care areas 3 times a week times 4 weeks then weekly ongoing. Any unusual variance will be addressed by Maintenance at the time of finding. Reported findings will be brought to the monthly QAPI meeting by the Administrator to review the need for continue intervention or amendment of the plan. Compliance Date: 08/16/2021	

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they had fixed a part that was broken because the hallways used to be hot as well.

A phone interview with the Regional Maintenance Director (RMD) on 7/13/21 at 9:34 AM revealed he had been covering for the facility's maintenance needs because the facility did not have a Maintenance Director. The RMD admitted that the whole air conditioning system broke in the beginning of June 2021 when there was no air going into the whole facility. The RMD stated a part of the air conditioning system broke and he ordered the part. After he replaced the broken part, he thought that the air conditioning system had been fixed. The RMD stated he did not check the individual rooms but only walked through the hallways and was not aware that air conditioning was still an issue with some of the rooms. The RMD denied that Resident #33 complained about the lack of air conditioning in her room.

A follow-up interview with Resident #33 on 7/13/21 at 9:55 AM revealed the RMD did fix her electrical issue in her room but she also told him about her concern related to the air conditioning system. Resident #33 stated the RMD just laughed and said to her that there was nothing he could do about it. The RMD further told her that they would need to replace the whole air conditioning system and that wasn't going to happen because it was an old building.

An interview with the Director of Nursing (DON) on 7/14/21 at 2:51 PM revealed she thought that the air conditioning system had been fixed. The DON knew they had ordered a part to get it fixed. She also knew that they had two different companies come and check if they could fix the

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air conditioning system. One company said the whole system needed to be replaced but it was just replaced three years ago so there was no way the facility would get a new air conditioning system.

A follow-up interview with the RMD on 7/14/21 at 4:25 PM revealed he had checked on the temperature in the hallways and in the rooms and found out that some of the rooms on the hall where Resident #33 resided were hotter than the hallway temperature. The RMD stated when the whole air conditioning system broke down in June 2021, he had two contractors assess the situation and one of them had recommended that the whole system needed to be replaced. The RMD stated the quote was outrageous and there was no way the facility would be able to get the whole air conditioning system replaced. The RMD stated the residents had the option of bringing in their own personal electric fans or they could try to pull cold air from the halls by using an electric fan.

An interview with the Administrator on 7/14/21 at 7:23 AM revealed he had talked to the owner on 7/8/21 about concerns at the facility and had brought up to him the problem regarding the air conditioning system. The Administrator knew there had been an issue with the air conditioning system and admitted that it used to be worse when even the hallways were hot and there was completely no air going into the whole facility. They experienced a delay in getting the issue fixed because they had ordered the wrong unit and had to order another one. He agreed that the facility needed to do some duct work to try to fix the air conditioning issue.

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2. Resident #30 was admitted to the facility on 5/4/2021 with diagnoses of congestive heart failure and chronic obstructive pulmonary disease and was dependent on oxygen therapy. Her quarterly Minimum Data Set (MDS) dated 7/4/21 revealed she was cognitively intact. She required limited assistance of one person for personal hygiene and bathing.

Observations on 7/12/21 at 9:30 AM revealed a personal resident fan utilized in room 108. A noticeable temperature difference could be felt between the 100-hall hallway temperature of that of room 108. The wall-mounted hallway thermostat read 76 degrees on 7/12/21 at 9:50 AM.

An interview with Resident #30 (room 108) on 7/12/21 at 10:36 AM revealed the room temperature had been too hot for her since her admission. She stated she had told the Nurse Aides (NA) and the Administrator about the warmth of the room. Resident #30 stated the Administrator told her the problem had been fixed. She could not tell the difference herself. She pointed to a standing oscillating fan with her name on it and said, "my son had to go buy me that so I could stand to be in here." Resident #30 was wearing oxygen via a nasal cannula. She stated the temperature made it more difficult to breathe.

A telephone interview with Resident #30's family member on 7/12/21 at 10:40 AM revealed he had complained to the facility about the heat since the resident's admission in May 2021. He could not recall the name of the person he spoke to. He informed he was first told a part was on order to

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repair the air conditioning and was later told the facility was looking to hire someone to install the part. After complaining again, the family member was informed the air conditioner had been fixed in June 2021. The temperature was still not cool enough for the resident, so the family purchased a fan for her.

Observation on 7/12/21 at 11:00 AM of facility thermostats on the 100-hall revealed a temperature reading of 75 degrees. Large suspended ducts in the hallway blew cool air into the hallways. Ceiling vents were present in resident rooms with slight air felt coming from the vents. There were no individual heating or air units in resident rooms.

An entry into Resident #30's room on 7/13/21 at 8:30 AM revealed the room continued to be noticeably warmer than the hallway.

An interview with NA #3 at 2:46 PM revealed Resident #30 had complained since her admission about her room being too hot.

An interview with NA #2 on 7/13/21 at 3:58 PM revealed Resident #30 had complained to her about the temperature in her room since she was admitted. NA # 2 stated the Administrator and Director of Nursing (DON) knew the room was uncomfortably warm. She stated she had been told that the problem was fixed.

An interview with the facility Administrator on 7/13/21 at 9:00 AM revealed the facility had been without a maintenance director since May 2021. He stated a new maintenance director had been hired on 7/12/21. The Administrator indicated the Regional Maintenance Director (RMD) had been

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F 584	Continued From page 13	F 584		

filling in when he could. The Administrator was aware of Resident #30's complaint but thought the issue had been resolved.

The Administrator was observed checking the 100-hall room air temperatures on 7/13/21 at 9:55 AM. The wall mounted thermostat in the hallway read 76 degrees. Using a hand-held air temperature monitor, the air temperature was checked from the doorway of Resident #30's room and read 73.8 degrees. The Administrator was asked to check temperature in center of room without the resident's fan on. The air temperature monitor read 73.8 degrees. The Administrator acknowledged the noticeable increased temperatures when crossing the threshold of room 108. The Administrator could not explain why the hallway temperature read 76 degrees and felt cooler than the resident rooms. He also could not explain why the hand-held air temperature monitor consistently read 73.8 degrees when there was a noticeable temperature variance between the hallway and the rooms. During the air-temperature check in Resident #30's room, the resident stated the room was so warm it was hard for her to breathe.

A telephone interview with the RMD on 7/13/21 at 9:33 AM revealed he was responsible for 9 facilities in different states. He presented to facilities when there was a problem that could not be fixed by on-site maintenance. He was aware there had been no maintenance coverage for approximately 3 months. The RMD was aware of previous complaints of temperatures being too hot. He stated the heating, ventilating, and air conditioning (HVAC) had been broken and needed a part at the beginning of June. He disclosed that the part had been installed in early

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F 584	Continued From page 14 June and he was not aware the rooms were still too hot. He stated the room temperatures would be checked today and tomorrow and he would fix the issue. An interview with the DON on 7/14/21 at 2:50 PM revealed she was aware there had been complaints about the temperature in room 108. She was under the impression that the issue had been fixed. The DON stated there had been a recommendation that the whole system be replaced, but she did not know the status of the recommendation.	F 584		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems.	F 636		8/16/21

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F 636	Continued From page 15 (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to complete the Care Area	F 636	F-636 Comprehensive Assessment and Timing	

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F 636	Continued From page 16 Assessment (CAA) that addressed the underlying causes and contributing factors for psychotropic drug use for 1 of 1 sampled resident (Resident #15). The findings included: Resident #15 was admitted to the facility on 5/24/21 with diagnoses that included bipolar disorder. The Admission Minimum Data Set (MDS) assessment dated 5/30/21 indicated Resident #15 was cognitively intact, exhibited no behaviors and had an active diagnosis of manic depression (bipolar disease). The MDS further indicated Resident #15 received antipsychotic and anti-anxiety medications for 7 days during the assessment period. The Care Area Assessment (CAA) for psychotropic drug use dated 5/30/21 stated Resident #15 was at risk of side effects of medications due to use of anti-anxiety medications and antipsychotic medications for diagnosis of bipolar disorder. There was no analysis of how she reacted or any benefits from the medications or how they impacted her day to day function. An interview with the MDS Nurse on 7/14/21 at 12:48 PM revealed she had started working for the facility in June 2021 but had only been there for a matter of days due to her always being pulled to another sister facility. The MDS Nurse admitted she hadn't really looked at Resident #15's assessment and when she filled out the CAA for psychotropic drug use, all the information she had was that she was receiving anti-anxiety	F 636	For resident #15 a new Care Area Assessment (CAA) was completed by the Minimum Data Sets (MDS) Coordinator on 7/29/2021, addressing the underlying causes and contributing factors for psychotropic drug use. This assessment also includes how resident #15 reacted to the anti-anxiety and antipsychotic medication and any benefits derived from taking this medication. The assessment also shows how the drug(s) impacted Resident #15s day-to-day function. All residents receiving psychotropic drugs have the potential to be affected. A 100% audit was completed of all CAAS on 8/6/21 by MDS Coordinator to ensure they have appropriate information. The MDS Coordinator was in-serviced by the Vice President (VP) of Reimbursement on 8/2/2021 related to ensuring the CAA's are complete and accurate for each resident understanding how to gather data and write a comprehensive CAA. Any new hires for MDS positions will be in-serviced upon hire by the MDS Coordinator. Director of Nursing or Unit manager will audit 8 residents CAAS weekly times 4 weeks, then once a month times 4 months to ensure all CAAS are accurate. Finding will be reported each month in Quality Assurance Performance Improvement (QAPI) by the Director of Nursing (DON)/Unit Manager (UM) to review the need for continued intervention or amendment of plan.	

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F 636	Continued From page 17 and antipsychotic medications. The MDS Nurse stated this was the way she had been doing the CAA and that nobody had ever said anything to her to do it differently. An interview with the Director of Nursing (DON) on 7/14/21 at 2:51 PM revealed Resident #15's CAA for psychotropic drug use should have included more information reflective of Resident #15 such as having anxiety, insomnia, verbal aggression, name-calling, short-term memory loss, withdrawn behaviors, depression and decline in mood. The DON added the MDS Nurse should have also included any potential indicators of side effects from psychotropic medications that Resident #15 was receiving such as episodes of lethargy and occasional slurred speech especially in the mornings. An interview with the Administrator on 7/14/21 at 4:33 PM revealed Resident #15's CAA for psychotropic drug use should have included more information specific to Resident #15 and each area checked off should have had supporting documentation of the basis/reason it was checked and the location of the source of information.	F 636	Compliance Date: 08/16/2021	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the area of	F 641	F-641 Accuracy of Assessments Resident #15's assessment was corrected	8/16/21

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F 641	Continued From page 18 Pre-admission Screening and Resident Review (PASRR) Level II for 1 of 1 resident reviewed for PASRR (Resident #15). The facililty also failed to code a resident accurately in the areas of active diagnoses and range of motion for 1 of 5 residents (Resident #25) reviewed for accidents. The findings included: 1. Resident #15 was admitted to the facility on 5/24/21 with diagnoses that included bipolar disorder. A review of Resident #15's medical record indicated Resident #15 had PASRR (Pre-admission Screening and Resident Review) Level II that started on 3/12/21 and ended on 6/10/21 for a mental illness. The Admission Minimum Data Set (MDS) assessment dated 5/30/21 indicated a "No" to question A1500 which asked if Resident #15 had been currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. An interview with the Social Worker (SW) on 7/14/21 at 8:47 AM revealed she did not realize that Resident #15 had a PASRR Level II when she was admitted to the facility. The SW stated she did not remember seeing a diagnosis for a severe mental illness except for bipolar disorder in Resident #15's medical record. The SW confirmed that Section A with regards to level II PASRR in Resident #15's Admission MDS was coded incorrectly because she had a level II PASRR at the time of her admission. An interview with the MDS Nurse on 7/14/21 at	F 641	by the Minimum Data Set (MDS) Coordinator on 7/29/2021 to accurately reflect the residents Preadmission Screening and Resident Review (PASSR) status. For resident #25 the MDS Coordinator corrected the assessment 7/29/21 to accurately reflect the resident's active diagnoses and range of motion. All residents with a Preadmission Screening and Resident Review (PASSR) level 2 have the potential to be affected by this practice and all residents have the potential to be affected related to inaccurate MDS assessments. The MDS Coordinator and social services director was in-serviced on accuracy of assessments on 8/2/21 by Vice President of Clinical Reimbursement. A 100% review of residents MDS assessments related to diagnoses and range of motion and level 2 PASSR's on 8/10/21 by MDS Coordinator. Social Services developed a list of residents and their PASSR status which is posted in the medication room to be updated monthly and as needed (prn) by the Social Services Director. The Director of Nursing or Unit Manager will conduct 8 MDS audits on accuracy of assessments times 4 weeks, then every two weeks times 4 weeks, then monthly times 3 months. Results of the audits will be brought before the Quality Assurance Performance Improvement (QAPI) Team each month by the Director of Nursing	

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12:48 PM revealed she had started working for the facility in June 2021 but had only been there for a matter of days due to her always being pulled to another sister facility. The MDS Nurse stated she had not been aware that Resident #15 was admitted to the facility with a level II PASRR and did not remember seeing a diagnosis for a severe mental disorder. The MDS Nurse added if she had known that Resident #15 had a level II PASRR when she was admitted to the facility, she would have done more research as to why before coding her as a level II PASRR on her Admission MDS and she would not have answered "No" to question A1500.

An interview with the Director of Nursing (DON) on 7/14/21 at 2:51 PM revealed Resident #15 should have been coded as a level II PASRR in her Admission MDS because she was admitted to the facility with a level II PASRR.

2. Resident #25 was admitted to the facility on 1/4/2017 with a diagnosis of paraplegia. The quarterly Minimum Data Set (MDS) assessment dated 7/1/21 indicated Resident #25 was cognitively intact and was totally dependent on two persons for transfers, personal hygiene, and bathing. The MDS further indicated Resident #25 had no impairment in range of motion in bilateral lower extremities.

An interview with Resident #25 on 7/12/21 at 9:15 AM revealed he could not use his legs and required assistance for "just about everything". He stated he could not get into or out of bed or transfer from bed to chair or chair to bed without assistance. Resident #25 stated he could maneuver somewhat once he was in his chair.

(DON)/Unit Manager (UM). The QAPI Team may determine the frequency or necessity of ongoing audits.

Compliance Date: 8/16/2021

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An observation of Resident #25 on 7/12/21 at 9:30 AM showed he was transferred from the bed to a wheelchair with a mechanical lift and two persons. He was observed to operate the manual wheelchair with footrests by pushing the wheels with his hands.

An interview with the MDS Coordinator on 7/14/21 at 12:55 PM revealed she was brought to the building in June to do MDS, but she was since pulled to another facility in another state, then went on vacation, and had "not gotten to" everything yet. She stated coding no impairment in range of motion in bilateral lower extremities as well as paraplegia was incorrect. When asked about the discrepancy in the MDS, she stated she had seen the resident in a wheelchair and assumed he could use his legs. She stated she did not verify the information with nursing staff or documentation. She voiced knowledge that she should have reviewed the documentation or spoken with nursing prior to coding the MDS.

An interview with the Director of Nursing (DON) on 7/14/21 at 3:18 PM revealed there had been no MDS staff since October 2020. The DON stated the facility had been sharing an MDS person with other sister facilities. The DON voiced Resident #25's MDS should have been coded "impairment on lower extremities" and "paraplegia." Her expectation of the MDS was that it was coded correctly.

An interview with the interim Administrator on 7/14/21 at 4:46 PM revealed there had been no consistent MDS staff since October 2020. He stated the current MDS Coordinator was shared between facilities and was not in the building regularly. He specified he expected the MDS to

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F 641	Continued From page 21 be coded correctly.	F 641		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to make a referral for re-evaluation after a Pre-admission Screening and Resident Review (PASRR) Level II expired for 1 of 1 sampled resident (Resident #15) for PASRR. The findings included: Resident #15 was admitted to the facility on 5/24/21 with diagnoses that included bipolar disorder. A review of Resident #15's medical record	F 644	All newly admitted residents' paperwork will be screened by the Social Service Director and the Minimum Data Set Coordinator (MDS Coordinator) to ensure a Level II PASARR does not expire and to incorporate any recommendations into the resident's plan of care. All residents who have a physician/psychologist visit, upon receipt, will have their notes reviewed for a new diagnosis of mental illness. Any resident with an ID or MI who has a significant change, will have a Level II PASARR referral.	8/11/21

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F 644	Continued From page 22 indicated Resident #15 had PASRR (Pre-admission Screening and Resident Review) Level II that started on 3/12/21 and ended on 6/10/21 for a mental illness. The Admission Minimum Data Set (MDS) assessment dated 5/30/21 indicated Resident #15 was cognitively intact, exhibited no behaviors and had an active diagnosis of manic depression (bipolar disease). Resident #15's History and Physical (H&P) note dated 6/2/21 by the Medical Director indicated since admission to the facility, Resident #15 pulled out her tracheostomy on 5/26/21 and refused to have it reinserted or to go to the ER (Emergency Room). Resident #15's H&P further indicated that Resident #15 had a prolonged hospital stay spending greater than 46 days in the ICU (Intensive Care Unit) due to her agitation and aggression which required multiple days of a sedative infusion. An interview with the Social Worker (SW) on 7/14/21 at 1:59 PM revealed she did not realize that Resident #15 had a PASRR Level II when she was admitted to the facility and that it had expired on 6/10/21. The SW stated this was the first case she had to get re-assessed for PASRR and admitted she did not know what she needed to do. The SW added she tried to get direction from the Social Worker at the local hospital and she was directed to call the NC (North Carolina) Tracks who forwarded her to the PASRR department. The SW shared she reached a dead end when she called the PASRR department and received a recorded message that they were not currently doing any training sessions due to COVID-19.	F 644	Social Service Director was in-serviced on 8/10/21 by RN consultant related to the Level II PASARR process. This education included:1) To be mindful of any expiration dates of the Level II PASARR and the renewal process of incoming admissions. 2) All newly diagnosed residents with a mental illness or intellectual disability, residents who have a significant change with a mental illness diagnosis, intellectual disability, residents exhibiting mood or behaviors which may signal the presence of a mental disorder, residents not previously identified, and those residents admitted or readmitted from an inpatient psychiatric stay should be referred for the Level II PASARR process. 3) Upon receipt of the Level II determination, any recommendations shall be incorporated into the residents' plan of care. A 100% chart audit was initiated on 8/10/21 and completed on 8/11/21 by the Social Service Director on to ensure no other PASARR Level II renewals and/or recommendations were not overlooked. No other resident required referrals at this time. Social Services/Minimum Data Set Coordinator, Director of Nursing and/or Unit Manager will review during clinical meetings within 24 hours or next business day all new admissions as well as residents in facility for significant changes, behaviors, or new Mental Illness or Intellectual Disability diagnoses to ensure referrals and/or incorporation of	

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F 644	Continued From page 23 An interview with the Director of Nursing (DON) on 7/14/21 at 2:51 PM revealed she was not sure about the process of renewing PASRR but agreed that a referral should have been made to get Resident #15 re-evaluated prior to her PASRR Level II expiring on 6/10/21. An interview with the Administrator on 7/14/21 at 4:33 PM revealed Resident #15 should have been re-assessed for PASRR prior to it expiring and the Social Worker was responsible for submitting the referral for PASRR re-evaluation.	F 644	recommendation by auditing 8 residents per week x 4 weeks. Then, every two weeks x 4 weeks, then monthly x 3 months. Results of the audits will be brought before the QAPI Team each month by the Social Services Director. The QAPI Team may determine the frequency or necessity of ongoing audits. Completion Date: 8/11/21	
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will	F 656		8/16/21

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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 656	Continued From page 24 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 review, staff interviews, and observations the facility failed to implement a care plan intervention for 2 of 4 residents (Resident #13 and Resident #11) reviewed for accidents and failed to develop care plans that addressed cognitive loss/dementia, behavioral symptoms, and psychotropic drug use 1 of 1 resident (Resident #18) reviewed for dementia. The findings included: 1. Resident #13 was admitted to the facility on 5/5/20 with diagnoses which included dementia. Review of Resident #13's quarterly Minimum Data Set (MDS) dated 5/21/21 revealed the resident was cognitively impaired and required extensive assistance with 2 people assist for all transfers.	F 656	A 100% audit of resident care plans and fall interventions was initiated on 8/6/21 and completed on 8/16/21 by the Minimum Data Set Coordinator (MDS), Director of Nursing (DON), and/or Unit Manager (UM) to ensure that the care plans accurately reflect each residents status related to fall interventions, diagnoses (which would include the use of psychotropic medications). When there is an update with the care plan or fall intervention the information will be updated by the MDS Coordinator, DON, and/or UM. The MDS Coordinator was in-serviced on August 2, 2021 by the VP of Clinical Reimbursement on the accuracy and development of care plans and fall	

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F 656	Continued From page 25 Review of Resident #13's care plan revised on 6/6/21 indicated that Resident #13 had a history of falls due to dementia. Interventions in place included Resident #13 needing a fall mat to the left side of bed and a call light within reach for Resident #13. An observation conducted on 7/12/21 at 11:29 AM revealed Resident #13 was in bed with no fall mat in place. Further observation revealed the resident's call light was not in reach and was placed on the floor between the left side of the bed and the side table. An observation conducted on 7/12/21 at 4:13 PM revealed Resident #13 was in bed with no floor mat and the call light was placed on the floor between the left side of the bed and the side table. An observation was conducted on 7/13/21 at 7:17 AM and revealed Resident #13 was in bed with no floor mat. An interview with Nurse Aide #4 on 7/13/21 at 2:20 PM revealed she assisted Resident #13 to bed and observed the resident's call light on the floor and was not in reach. Nurse Aide #4 further revealed she could not recall the last time Resident #13 had a fall mat. An interview with Nurse #4 on 7/13/21 at 3:30 PM revealed Resident #13 usually had a fall mat but could not recall why the resident didn't have one. Nurse #4 stated Resident #13 did have a fall mat but she did not recall why Resident #13 no longer had one. Nurse #4 did not know Resident #13's call light was on the floor but revealed that it	F 656	interventions. Any new MDS hires will receive the education upon hire by the VP of Clinical Reimbursement. All nursing staff was in-serviced beginning 8/2/21 to 8/12/21 by DON related to reviewing and following residents plan of care regarding fall interventions, care plans and the diagnoses and use of psychotropic medications. All new hires in the nursing department will receive this education during their orientation period by Staff Development Coordinator, Unit Manager, or Director of Nursing (DON). Any nursing staff that has not worked during this time period will receive this education prior to the start of their next working shift by the DON, Staff Development Coordinator or UM. The DON/UM/MDS Coordinator will audit 8 resident care plans for accuracy and implementation weekly x 4 weeks, then every two weeks x 2 weeks, then monthly times 3 months to ensure all residents care plans have been addressed. Results of the audits will be brought before the QAPI Team each month by the DON/UM. The QAPI Team may determine the frequency or necessity of ongoing audits. Completion Date: 8/16/21	

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should have been within reach of Resident #13.

An interview with the Director of Nursing (DON) on 7/14/21 at 2:50 PM revealed Resident #13 did not have a fall mat and was expected to have a fall mat and the call light to be within reach of Resident #13.

An interview with the Administrator on 7/14/21 at 4:33 PM revealed Resident #13 should have had a fall mat and a call light within reach. The Administrator further revealed all care plans were expected to be followed.

2. Resident #11 was admitted to the facility on 2/3/21 with diagnoses which included abnormal involuntarily movements, lack of coordination, muscle weakness, and repeated falls.

Review of Resident #11's quarterly Minimum Data Set (MDS) dated 5/7/21 revealed Resident #11 was cognitively impaired and required limited assistance with one person assist for all transfers.

Review of Resident #11's care plan revised on 6/6/21 indicated Resident #11 was at risk of falls with history of frequent falls. Interventions in place included Resident #11 needed falls mats on both sides of the resident's bed.

An observation conducted on 7/12/21 at 9:40 AM revealed Resident #11 was in bed flipping through a magazine with a floor mat placed on the left side of the resident's bed.

An observation conducted on 7/12/21 at 4:15 PM revealed Resident #11 was in bed with a floor mat placed on the left side of Resident #11's bed.

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An observation was conducted on 7/13/21 at 7:21 AM and revealed Resident #11 was in bed with a floor mat placed on the left side of Resident #11's bed.

An interview with Nurse Aide #4 on 7/13/21 at 2:20 PM revealed Resident #11 had two falls mats, but a staff member took one of the mats for another resident. Nurse Aide #4 further revealed she could not recall what the resident was care planned for.

An interview conducted with Nurse #4 on 7/13/21 at 3:30 PM revealed Resident #11 had multiple falls from her bed since admission. Nurse #4 further revealed Resident #11 had two fall mats at one time but could not recall why there was only one.

An interview conducted with the Director of Nursing (DON) on 7/14/21 at 2:50 PM revealed Resident #11 was care planned for two falls mats, but only had one. The DON further revealed she added a fall mat for Resident #11 on 7/14/21 around lunch time. The DON stated it was expected for Resident #11's care plan to be followed.

An interview conducted with the Administrator on 7/14/21 at 4:33 PM revealed Resident #11 was expected to have two fall mats and the care plan to be followed as revised.

3. Resident #18 was admitted to the facility on 5/17/21 with diagnoses of dementia with behavioral disturbance and diabetes. Her admission Minimum Data Set (MDS) revealed

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she was moderately cognitively impaired with episodes of disorganized thinking and inattention. She was coded as having behaviors of rejection of care and wandering. Resident #18 required extensive assistance of one person for bed mobility, toileting, and personal hygiene. Resident #18's Care Area Assessment (CAA) identified the need of care plans for cognitive loss/dementia, behavioral symptoms, and psychotropic drug use.

A review of the medical record on 7/13/21 at 9:18 AM revealed no focused care plans for dementia with behaviors, use of psychotropic medications, or diabetes. The medical record further showed Resident #18 was prescribed an antipsychotic medication as well as oral medication and insulin for diabetes. The record showed a psychiatric evaluation was completed on 6/21/21 with medication adjustments recommended and completed. Review of the 7/2021 Medication Administration Record (MAR) showed Resident #18 had one episode of refusing insulin.

An interview with the Rehabilitation Director (RD) on 7/13/21 at 10:36 AM revealed Resident #18 was impulsive and often packed up items (a book, a teddy-bear, and a blanket) to carry with her when moving from her room to the therapy department. The RD indicated he had not observed Resident #18 loitering near doors or any other exit-seeking behaviors from the resident.

An interview with Nurse Aide (NA) #3 on 7/13/21 at 2:46 PM revealed Resident #18 had not been combative or aggressive but was intermittently cooperative from day to day.

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F 656	Continued From page 29 An interview with the MDS Coordinator on 7/14/21 at 12:55 PM she had not checked all the care plans yet. An interview with the Director of Nursing (DON) on 7/14/21 at 3:18 PM revealed the facility had not had a MDS or care plan staff since October 2020. The DON stated a shared MDS Coordinator was sent to the facility in June but had been sent to another facility shortly after her arrival. The DON stated a care plan should have been initiated as all nurses were able to edit care plans. An interview with the interim Administrator on 7/14/21 at 4:44 PM revealed he expected a baseline care plan to be initiated immediately after admission. He stated he expected a full comprehensive care plan to be completed within a week.	F 656		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census.	F 732		7/30/21

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F 732	Continued From page 30 §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to post daily nurse staffing information on 3 of 3 days during the survey. The findings included: A tour of the facility was made on 7/12/21 at 10:00 AM. The daily nurse staffing information was located on a table in the front lobby of the facility. The date on the daily nurse staffing sheet read 6/14/21. An observation of the daily nurse staffing information was completed on 7/13/21 at 11:55 AM. The date on the daily nurse staffing sheet	F 732	F-732 Posted Nurse Staffing information Residents Affected: No specific residents were mentioned as being affected by this practice. Residents Potentially Affected: No residents of the facility have the potential to be affected by this practice. Systemic Measures: The Administrator and DON inserviced the Scheduler and the Receptionist on July 30, 2021 on use of the form. The Scheduler was also inserviced on the importance of ensuring that the schedule	

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F 732	Continued From page 31 read 6/14/21. An observation was made on 7/14/21 at 10:27 AM. The date on the daily nurse staffing sheet was 6/14/21. An interview with the Director of Nursing (DON) on 7/14/21 at 10:30 AM revealed she thought the person responsible for completing the form had written 6/14/21 instead of 7/14/21. A comparison review of the daily nurse staffing information and the daily schedule was completed by the DON. The DON acknowledged the schedule did not match the posted daily nurse staffing information. The DON stated the scheduler responsible for maintaining the daily posting was on vacation and another person was covering her duties. The DON revealed the person filling in for the scheduler had not been instructed to complete the sheet. A review of the daily nurse staffing sheets from April through July 2021 revealed the daily nurse staffing sheet had been completed on 13 days. A subsequent interview with the DON on 7/14/21 at 3:24 PM revealed she expected the daily nurse staffing sheet to be completed and posted daily. An interview with the facility Administrator on 7/14/21 at 3:30 PM revealed he expected the daily nurse staffing to be updated and posted daily. He stated he expected the posting to include changes such as callouts and any staff schedule changes.	F 732	and the posting match. Upon changes in either the schedule or the posting, they must be changed. Monitoring Measures The Posting Form will be monitored by the DON, Charge Nurses or Administrator Monday through Friday for one month, then every other week for one month, then monthly thereafter. Any discrepancies will be corrected during the review. Results of these reviews will be brought before the QAPI Team each month. The QAPI Team may determine the frequency or necessity of ongoing reviews. The Team at a minimum, consists of the Administrator, Director of Nursing, three other Department Managers and other team members as assigned or requested. Date of completion 7/30/2021	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		8/2/21

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F 761	Continued From page 32 §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to discard an expired medication available for use in 1 of 1 medication room. The findings included: An observation was made of the medication room with Nurse #1 on 7/14/21 at 6:57 AM. A bottle of Hydromorphone, a narcotic used to treat moderate to severe pain, with approximately 45 ml (milliliters) in the bottle was observed inside the locked refrigerator in the medication room	F 761	Nursing staff was educated on removal of expired medications on 8/2/21 by Director of Nursing (DON). All newly hired licensed nurses will be educated on the removal of expired medications during their orientation. Any licensed staff who was not working during this time will be in-serviced on removal of expired medications prior to the start of their next shift. Monitoring/audit of the medication room and medication carts will be done by the	

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F 761	Continued From page 33 and was available for use. The bottle was labeled with Resident #85's name and was dispensed to the facility on 3/24/21. The label further indicated that it was supposed to be discarded after 5/23/21. An interview with Nurse #1 on 7/14/21 at 7:00 AM revealed the nurses forgot to return the bottle of Hydromorphone back to the pharmacy. Nurse #1 stated Resident #85 was no longer in the facility and the nurse who took care of Resident #85 when he died at the facility probably meant to return the bottle of Hydromorphone to the pharmacy but it was locked up in the refrigerator in the medication room so they probably forgot to take it out and put it in the box of medications to be returned to the pharmacy. Nurse #1 stated she worked the night before and she was supposed to check the medication room for expired medications but forgot to look in the locked medication refrigerator for controlled medications. An interview with the Director of Nursing on 7/14/21 at 2:51 PM revealed expired medications were supposed to be discarded but since the bottle of Hydromorphone was a controlled medication, it should have been sent back to the pharmacy when no longer needed. The DON stated the night shift nurses usually scanned or filled out the list of medications to be returned to the pharmacy and probably missed the bottle of Hydromorphone because it was locked up in the refrigerator. The DON stated the night shift nurses should have checked the medication room for expired medications.	F 761	Director of Nursing or Unit Manager weekly x 4 weeks, then every two weeks x 4 weeks, then monthly thereafter to ensure no expired medications remain in the facility. The Pharmacy Consultant will also address this on monthly visits. Results of the audits will be brought before the QAPI Team each month by the DON/UM. The QAPI Team may determine the frequency or necessity of ongoing audits. Completion date: 8/2/21	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		8/6/21

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F 880	Continued From page 34 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other 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:	F 880		

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F 880	Continued From page 35 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations and staff interviews, the facility failed to implement their infection control policies and procedures when 2 of 2 staff members (Nurse #2 and Nurse #3) failed to disinfect a glucometer according to manufacturer's recommendations after use on 2 of 2 residents (Resident #8 and Resident #14) reviewed for infection control. These failures occurred during a COVID-19 pandemic. The findings included:	F 880	The facility policy titled Glucometer Use and cleaning was placed in the binder on each medication cart on 7/28/21. During change of shift, the medication cart is checked to ensure appropriate disinfecting wipes are available on the cart by the oncoming nurse. Beginning 7/28/21to 8/6/21,licensed nursing staff and medication technicians were in-serviced by Director of Nursing on the facility policy of how to disinfect the	

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F 880	Continued From page 36 A review of the facility's policy entitled, "Glucometer Use and Cleaning," dated 5/18/20 indicated the following direction after using the glucometer: * Use a Micro-Kill+ Bleach to wipe the glucometer of any visible materials covering all surfaces. * Use an additional wipe to allow the glucometer to remain moist for 3 minutes and allow to air dry and return to storage case. The manufacturer's Operator's Manual for the glucometer used at the facility indicated the following instructions regarding disinfecting procedures for the meter: * To disinfect the meter, clean the meter surface with one of the approved disinfecting wipes. Other EPA (Environmental Protection Agency) registered wipes may be used for disinfecting the glucometer; however, these wipes have not been validated and could affect the performance of the meter. Wipe all external areas of the meter including both front and back surfaces until visibly wet. Allow the surface of the meter to remain wet at room temperature for the contact time/kill time listed on the canister. The manufacturer's recommendations for the Solimo disinfectant wipes included the following disinfection/virucidal directions: * Wipe hard, non-porous surface with wipe until surface is visibly wet. Use enough wipes to keep surface visibly wet for 4 minutes. * Allow surface to remain wet for 4 minutes. Let air dry. 1. An observation was made on 7/13/21 at 7:21 AM of Nurse #2 checking Resident #8's blood	F 880	residents glucometer. All new hires will be in-serviced on this procedure during the orientation process by Director of nursing (DON)/ Unit Manager (UM)/ Registered Nurse (RN) supervisor. All licensed nursing staff and medication technicians who were not at the in-service, will be in-serviced on the facility policy for disinfecting resident glucometers prior to the start of their next shift by DON/SDC/UM/RN supervisor. Audits of observation of glucometer disinfecting will be observed 3 times a week x 4 weeks, then weekly thereafter by the Director of Nursing (DON) and/or Unit Manager (UM). The DON will review the audits and present to the QAPI Team. The QAPI Team may determine the frequency or necessity of ongoing observations/audits. Completion date: 8/6/21	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345307	A. BUILDING _____ B. WING _____	C 07/14/2021

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sugar. After wiping Resident #8's right fourth finger with an alcohol wipe, she stuck it with a single use lancet and placed a drop of blood into the strip that was inserted in a glucometer. After the reading registered on the glucometer, she removed the strip and discarded it while placing the glucometer back into Resident #8's individual case. Nurse #2 walked back to the medication cart on the hall and placed the case which had Resident #8's glucometer inside the medication cart and locked it.

An interview with Nurse #2 on 7/13/21 at 11:34 AM revealed glucometers were supposed to be cleaned and disinfected after using each time, but she did not have disinfectant wipes available in her medication cart earlier. Nurse #2 admitted that she just remembered that she was supposed to disinfect the glucometers in her medication cart and that she was going to get some disinfectant wipes.

2. An observation was made on 7/13/21 at 11:05 AM of Nurse #3 checking Resident #14's blood sugar. Nurse #3 cleaned Resident #14's left third finger with an alcohol wipe and then stuck it with a single use lancet. Nurse #3 applied a drop of blood into the strip that was inserted in a glucometer. After the reading registered in the glucometer, Nurse #3 removed her gloves and started walking towards the medication cart while holding the glucometer and other supplies used to check Resident #14's blood sugar. Nurse #3 discarded her gloves in the trash can and disposed of the lancet in the sharp's container. She then applied another set of gloves and pulled out a canister of Solimo disinfectant wipes from the bottom drawer of the medication cart. Nurse #3 pulled a disinfectant wipe from the Solimo

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canister and started wiping the front and back of the glucometer which took about five seconds. Nurse #3 placed the glucometer back into Resident #14's individual case and locked it in the medication cart.

After reviewing with Nurse #3 the instructions on the Solimo disinfectant wipes canister that indicated to allow the surface to remain wet for 4 minutes and allow to air dry, an interview with Nurse #3 on 7/13/21 at 11:10 AM revealed she was aware that she was supposed to leave the glucometer to air dry but she forgot.

An interview with the Infection Preventionist (IP) on 7/14/21 at 8:24 AM revealed glucometers were supposed to be disinfected after each use. The IP added that glucometers were supposed to be only disinfected using Micro-Kill bleach wipes which were listed in the glucometer's manufacturer's recommendations as approved to be used on their glucometers. The IP stated Nurse #3 should not have used the Solimo disinfectant wipes because these were intended to be used only to disinfect frequently touched surfaces.

An interview with the Director of Nursing (DON) on 7/14/21 at 2:51 PM revealed the facility had plenty of Micro-Kill bleach wipes available and both Nurse #2 and Nurse #3 should have had some in their medication carts. The DON stated the IP told her that she had just placed a new canister of Micro-Kill disinfectant wipes in each medication carts the week before and was not sure why they had run out in such a short time. The DON further stated the Micro-Kill bleach wipes were supposed to be used only to disinfect glucometers but might have been used to

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F 880	Continued From page 39 disinfect general surfaces which they should have used the Solimo wipes for. In any case, the nurses should have followed the instructions on the label regarding disinfection and contact/kill time.	F 880		