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MONROE REHABILITATION CENTER	1212 SUNSET DRIVE EAST MONROE, NC 28112

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E 000	Initial Comments An unannounced Recertification survey was conducted on 10/18/21 through 10/26/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #3QKW11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 10/18/21 through 10/26/21. Event ID# 3QKW11. 3 of the 19 complaint allegations were substantiated.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, resident and staff interviews, the facility failed to assess the ability of a resident to self-administer an inhaler, eye drops and nebules for a nebulizer treatment that she kept at the bedside for 1 of 1 resident (Resident #88) reviewed for self-administration of medications. The findings included: Resident #88 was admitted to the facility on 9/30/18 with diagnoses that included chronic obstructive pulmonary disease (COPD) and dry eyes.	F 554	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. F554 Resident Self-Admin Meds-Clinically Appropriate What was done for the resident: Resident#88 was not harmed by the	12/6/21

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

Electronically Signed | 11/18/2021

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F 554	Continued From page 1 Resident #88's care plan revised on 7/12/21 indicated Resident #88 was at risk for impaired gas exchange/ineffective airway clearance related to COPD. Interventions included medications/treatments as ordered. The care plan did not include that Resident #88 was able to administer her own medications. The quarterly Minimum Data Set (MDS) assessment dated 9/14/21 indicated Resident #88 was cognitively intact, able to communicate and could be understood. Resident #88 was independent with all activities of daily living except bathing. No behaviors were indicated. A review of Resident #88's electronic medical record revealed no assessment for self-administration of medications. The Physician's Orders in Resident #88's medical record included the following medication orders: 1. Ipratropium-Albuterol inhaler - inhale 1 puff orally two times a day for COPD. This was an active order that was started on 8/7/20. 2. Fluticasone inhaler - inhale 1 puff orally one time a day for COPD. Rinse mouth with water after use. Do no swallow. This was an active order that was started on 5/25/21. 3. Cyclosporine Emulsion eye drops - instill 1 drop in both eyes one time a day for dry eyes. This was an active order that was started on 10/1/18. 4. Ipratropium-Albuterol solution - 3 ml (milliliters) inhale orally via nebulizer every 4 hours as needed for shortness or wheezing for 3 days. This was an inactive order that was started on 1/1/20 and ended on 1/4/20. An observation of Resident #88 on 10/18/21 at	F 554	alleged deficient practice. Resident #88 was evaluated for self-administration of medications and was deemed not to be able to safely administer medications. Resident #88 and responsible party were informed by whom of the results of the evaluation and voiced understanding. The MD and responsible party were also made aware of the observation during the dates of the survey. No orders were received from the physician. Identification of other residents: Residents who receive medication at the facility are at risk for the deficient practice. Nurse #6 and Nurse #2 were educated on the policy regarding self-administration of medications. A sweep of resident rooms to identify other residents with medications stored for self-administration was completed by the Facility Guardian Angels. The facility guardian angels are the department heads and include Staff Development Coordinator (SDC) Director of Nursing (DON), Activities Director, Administrator and Therapy Manager and others as delegated by the administrator. The sweep of the rooms was completed on or by 11.17.2021. No other residents were noted to be affected. Systemic changes All staff will be educated by the SDC and or designee by 12.02.21 regarding observing resident rooms for medications at the bedside.	

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F 554	Continued From page 2 11:38 AM revealed an Ipratropium-Albuterol inhaler and a Fluticasone inhaler on her bedside table. An interview with Resident #88 during the observation revealed she had the inhalers at the bedside because she couldn't take both at the same time and had to space them out, so the nurse left them for her to administer to herself. Resident #88 stated she knew how to administer the inhalers to herself and the nurse forgot to pick them up after she had used them. An interview with Nurse #2 on 10/21/21 at 10:07 AM revealed she had worked with Resident #88 on 10/18/21 for the first time and had observed Resident #88's inhalers at the bedside before she even started to give her medications to her. Nurse #2 stated she observed Resident #88 take her inhalers, but Resident #88 requested for her to leave them in the room with her so she left the inhalers at Resident #88's bedside. Nurse #2 stated she was not sure if Resident #88 could keep her medications at the bedside but knew some of the residents liked to keep medications at the bedside. She was also not sure whether Resident #88 had been assessed to self-administer her medications. A second observation of Resident #88 on 10/20/21 at 9:58 AM revealed an intact single use dropper of Cyclosporine eye drops on her bedside table. An interview with Resident #88 during the observation revealed she was saving the eye drop and was going to put them on her eyes herself when she laid down in bed. An interview with Nurse #6 on 10/20/21 at 10:11 AM revealed Resident #88 liked to put her eye drops on her own eyes and always requested to leave her medications at the bedside, but Nurse	F 554	Monitoring The Guardian Angel rounding forms will be revised to include monitoring resident rooms for medications at the bedside. The Guardian Angels will conduct random weekly audits of 5 rooms per week for 12 weeks. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	

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F 554	Continued From page 3 #6 stated she never left Resident #88's medications at the bedside. Nurse #6 stated she had just given Resident #88 her medications which included her eye drops and did not recall leaving them at the bedside for Resident #88 to administer to herself. A third observation of Resident #88 on 10/20/21 at 10:14 AM with Nurse #6 revealed 5 single use droppers of Cyclosporine eye drops and 3 nebules of Ipratropium-Albuterol solution in the top drawer of Resident #88's side table. Resident #88 stated the other nurses left the medications for her and gave her extra in case she needed more. Nurse #6 collected the medications at the bedside while explaining to Resident #88 that she could not keep them there. An interview with the Interim Director of Nursing (DON) on 10/21/21 at 3:52 PM revealed Resident #88 had not been assessed as able to administer medications to herself and should not have medications at the bedside.	F 554		
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	F 563		12/6/21

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F 563	Continued From page 4 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, observations and staff and family interviews the facility limited visitation for the convenience of the facility to the outdoor front entrance or the admission office for regular visitation and failed to allow private visits for 4 of 4 resident representatives interviewed (Resident #16, #18, #48, #55). Findings include: The Resident census on 10/18/21 was 119. The county positivity rate on 10/19/21 was 8.3% which was moderate level. The resident vaccination rate was 80% per the Administrator on 10/18/21 at 10:25 AM. The facility was noted to be in a COVID-19 outbreak status as of August 2021 per the Health	F 563	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. F563 Right to Receive/Deny Visitors How was it corrected for the resident identified? Resident #16, #48, and #55 representatives were called by whom on 11/17/2021 to validate they can visit as desired. Resident #18 was not on the resident roster.	

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Department during an interview with the Administrator on 10/21/21 at 3:01 PM. March 2021 thru July 2021 the Administrator had said they were not in outbreak status.

Review of a letter sent to families on 08/29/21 stated "we allow indoor visitation in a common area when requested ahead of time and we allow limited in-room visitation according to specific situations, such as compassionate care or end-of-life. In these situations, if it is a semi-private room, ideally the roommate would be absent from the room, and requested that appointments be made to visit with residents."

Review of the facility's website information from 10/20/21 indicated the instructions to schedule a visit. The website noted indoor, outdoor and compassionate care visits would be by appointment only.

Resident #55 was admitted to the facility on 04/11/08. The resident was residing in a semi-private room on the memory care unit but had not had a roommate for the majority of 2021.

The Minimum Data Set (MDS) quarterly assessment dated 08/11/21 indicated Resident #55 was not cognitively intact and she had an elopement bracelet on due to multiple elopement attempts.

A phone interview was conducted on 010/19/21 at 06:59 PM with a family member of Resident #55. The family member stated they had to set up an appointment to see the resident. He stated they had never been able to walk in and visit her since COVID started in March 2020. He said he must call ahead even to take her out for visits. The

How it was corrected for other residents identified.
All residents have the potential to be affected.
Administrator educated facility leadership team on the expectations that the facility will allow visitation at all times. This education was completed on 11/19/2021.

Systemic Changes:
The facility staff have been educated regarding the visitation policy by the Administrator/Director of Nursing (DON)/Staff Development Coordinator (SDC). The facility website was updated, and families were notified via the website, by phone and or by mail on or before November 22, 2021. Going forward, if changes or updates occur to the visitation policy the Administrator/Social Services/Designee will ensure the facility staff are informed of the changes, the facility website is updated and that the families are notified.

Monitoring:
A random audit will be conducted by the Social Worker or designee of 5 resident representatives per week to ensure they are able to visit as desired. This audit will be conducted for 12 weeks.
Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Social Worker monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.

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family member noted they were not allowed to visit the resident in her room. He further stated the facility mandated all visits to occur outdoors in the front of the facility at the entrance. He stated he would like to go to the resident's room and visit with her in private.

The visitation calendar revealed that Resident #55's family member picked her up for a home visit on 10/20/21 at 11:00 AM.

Review of the visitation calendar for Saturday 6/12/21 indicated 1 visitor was scheduled at 10:00 AM, 11:00 AM, 1:00 PM, 2:00 PM and 3:00 PM, permitting 5 visits for the day, all outside.

Review of the Saturday 7/10/21 visitation schedule indicated 2 visits were scheduled at 9:00 AM, 3 at 10:00 AM, 2 at 11:00 AM-1 of which was noted to be inside, 1 visitor at 1:00 PM, 1 at 2:00 PM and 2 at 3:00 PM. 11 visits were scheduled for the day with 1 of the visits being inside.

A review of the Tuesday 9/21/21 visitation schedule revealed that 1 visitor was scheduled at 9:00 AM, 1 at 10:00 AM inside the room, 2 at 11:00 AM with a 3rd resident scheduled to be picked up for a visit, 1 visitor at 3:00 PM and 2 visitors at 4:00 PM. There were 7 facility visits scheduled total with 1 being an indoor visit.

Review of the visitation calendar from Saturday 10/09/21 indicated 2 outdoor visits were scheduled at 9:00 AM, 3 visits at 10:00 AM and 2 outdoor visits at 11:00 AM. A note for 1 of the 10:00 AM visits indicated it would be in the admission office and the resident's room per the Administrator. Outdoor visits resumed at 2:00

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PM for 3 residents for 45 minutes and 2 visits at 3:00 PM, 4:00 PM and 5:00 PM. 16 visits were scheduled for the day, with 15 being outside visits.

An observation was done on 10/20/21 at 2:30 PM of visitors with the residents under the front entrance canopy. The open space was set up for 3 seating areas spaced at least 6 feet apart. There were 2 visitations occurring at that time under the canopy. The outside temperature was 81 degrees.

An interview was done on 10/21/21 at 02:25 PM with Resident #48 and the family member during scheduled visitation outside the front entrance. She said she came on Tuesdays and Thursdays. She said she was unable to visit long, as the resident was at the stage that he could not handle sitting up that long. She said she thought the visits were for 45 minutes, but she never was able to use the entire time. She stated she had scheduled it every week on specific days. She noted it was a problem if she had to reschedule a visit, because the other days were booked so she had to keep her day. The family member said she would love to visit inside, but the visits were outside and when the resident's back hurt, he was ready to go back in. She was concerned what they would do when it gets cold.

An interview was done on 10/21/21 at 2:30 PM with a family member outside of the front entrance visiting Resident #16. He indicated he lived 50 miles away, so they didn't come often. He said they called and scheduled a visit. He said the resident did not like to sit outside long so they visited till the resident was ready to go in. He recalled the last time he visited, it was a

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breezy day, so his visit was cut short as the resident wanted to go back inside.

The family member of Resident #18 was interviewed on 10/21/21 at 3:08 PM while visiting outdoors at the front entrance. The family member stated he visited once a week and they had to schedule it. He noted he typically visited in the afternoon because it was warm, and the visits were for 45 minutes. The visitor said the resident had been there since December 2020 and they had yet to be in the building. He said the times they could schedule a visit were 9:00-11:00 AM and 1:00-4:00 PM, 7 days a week.

An interview was conducted on 10/21/21 at 10:51 AM with Receptionist #1 regarding family visitation. She noted she was responsible for scheduling family visits. She stated if families want to schedule a visit it had to be scheduled at least 24 hours in advance, only 2 people were allowed per visit, and all visits are limited to 45 minutes. Compassionate care visits were inside and limited to 45 minutes. She noted visitations were from 9:00 AM to 4:00 PM on the hour and if they had family coming from far away, they would do a 5:00 PM visit for them. The hours were the same 7 days a week. She stated the only exception that was made was for a resident actively passing. She noted if someone just showed up to visit, they could not visit, she had to explain they must schedule a visit at least 24 hours in advance, no exceptions.

The Administrator was interviewed on 10/20/21 at 09:00 AM regarding family visits. The Administrator shared that they had calendars that had been set up for standing visiting appointments with the receptionist. She noted

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that some families had set-up recurring appointment times. She said that prior to the outbreak, she had one family she had to accommodate, and allowed her to come into the resident's room. They could not now as they were in outbreak status. She said the front desk had a list of residents to allow family visits with hospice and for new admissions if needed, and they are much more liberal with these families. The Administrator said they sent a letter regarding visitation about 6 weeks ago to families and they tried to accommodate visits. She said most visits were outside on the porch, and she did not like visits at lunch and most people have roommates, so they don't allow in room visits.

A follow-up interview was done with the Administrator on 10/21/21 at 10:57 AM about family visitation. She stated they had referenced the QSO memo, and the guidelines given when facilities didn't have adequate space. She stated they always preferred outdoor visitation, however if there were bad weather or special circumstances, they would use the admission office as a secondary location for a visit. The admission office was located immediately inside the front entrance. The Administrator noted if it was for compassionate care visitation or the family really needed to see the resident-such as a new admission, they would schedule a room visit but it disturbed the roommates, so they tried to stay away from in room visitation. She said no visitation in the evening was scheduled. She stated if family came to the door and needed to be accommodated, they would try and do that, and staff should tell her in those situations and then they would be informed to schedule in the future.

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F 563	Continued From page 10 A follow-up interview was done with the Administrator on 10/21/21 at 03:01 PM. She stated there had been no COVID 19 positive cases from when she arrived at the facility on 3/29/21 until July 31st. She noted their outbreak status started in August 2021 and the facility had not been out of an outbreak since. She stated the health department told them when they needed to restrict visitation during outbreaks, and it had not been restricted yet.	F 563		
F 584 SS=E	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, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition;	F 584		12/6/21

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F 584	Continued From page 11 §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 observations and staff interviews the facility failed to: 1a) failed to remove brown substance in 1 of 3 shower rooms (Shower room 127) and 1 out of 25 restrooms (Room 109's Bathroom), 1b) and failed to ensure the resident rooms were free from damaged drywall in 2 of 25 rooms (208 and 210), 1c) failed to clean the Packaged Terminal Air Conditioner (PTAC) filters for 2 of 25 rooms (Resident room 356, Resident room 209) 1d) failed to maintain sanitary condition for 9 of 25 residents rooms (Room 356, Room 110, Room 109's bathroom, Room 132, Room 125, Room 210, Room 209, Room 208, Room 207), and 1e) failed to ensure the resident rooms were free from build-up of dust and debris in 2 of 25 rooms (Room 356, Room 115) and 1f) failed to remove brown, red, and black substance from wall, assist bar, and behind toilet in 3 of 25 rooms (Room 110's bathroom, Room 125's bathroom, and Room 207's bathroom) , and 1g) repair ceiling in 1 of 3 shower rooms (Shower room 127) and baseboards in 3 of 25 rooms (Room 335, Room	F 584	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. F584 Safe/Clean/Comfortable/Homelike Environment What was done for the affected resident: No resident was noted to be affected by the alleged deficient practice. All 3 shower rooms were cleaned, and the brown substance noted in 1 of 3 was removed. Rooms 200 and 210 damaged drywall was fixed. The PTAC filters for rooms 356 and 209 were cleaned by housekeeping staff. Resident Rooms 356, 110, 100, 132, 125, 210, 209, 208, 207 were deep	

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F 584	Continued From page 12 356, and Room 132) Findings included: 1a. An observation on 10/20/21 at 9:10 AM Shower Room 127 with tissue on floor with brown substance, and toilets with brown substance on it. Observation further revealed at 10:41am restroom 109 toilet with brown substance and brown substance to the back of toilet. 1b. An observation on 10/20/21 at 10:56am Room 210 Bed A noted with visible damage to drywall behind the bed with a hole. Observation of Room 208 Bed A with visible damage to dry wall. 1c. On 10/20/21 at 9:38 AM observation of room 356 revealed PTAC unit grates with dust build up, food particles, spider webs and debris. Observation at 10:56am of Room 209 Bed B dust under PTAC unit. 1d. An observation on 10/20/21 at 9:10 AM Shower Room 127 with tissue on floor with brown substance, and toilets with brown substance on it. On 10/20/21 at 9:38 AM observation of room 356 revealed baseboard noted to be dirty with brown substance found on wall located by bed B. Observation at 10:38 am bathroom of Room 110 revealed black substance behind toilet. Observation further revealed at 10:41am bathroom of Room 109 toilet with brown substance, brown substance to the back of toilet. An observation at 10:42am Shower room 111 revealed used brief in trash, and wash cloth balled up in corner of the shower. Further observation at 10:45am in Room 132 sticky substance to floor at the end of the bed. At 10:48am observation of Room 125's bathroom revealed brown staining to floor around the toilet.	F 584	cleaned by the housekeeping staff. Resident rooms 356 and 115 were cleaned and are free of dust and debris. The brown, red and black substance noted on the wall, and on the assist bar and behind the toilet in rooms 110, 125, 207 was removed. The ceiling in the shower room located 127 ceiling was fixed. The shower rooms baseboards and baseboards in rooms 335, 356, 132 were in good condition. All noted deficient practices were corrected by either the maintenance or housekeeping staff on or before 11/19/2021. How to correct for other identified with: All current residents have the potential to be affected by the alleged deficient practices. NHA, EVS Account Manager and Maintenance Director conducted an audit throughout the facility to ensure that the shower rooms and restrooms were clean, residents□ rooms were free from damaged drywall, PTAC filters were cleaned in resident rooms, resident rooms were in sanitary condition to include dust and debris, ensure bathrooms were clean and sanitary, ensure ceilings and baseboards are in good repair. This audit will be conducted by 11/22/2021. Opportunities corrected as identified. NHA educated EVS Account Manager on the expectation that all resident rooms, bathrooms, shower rooms are clean and sanitary. This education was conducted on 11/18/2021. Systemic Change:	

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F 584	Continued From page 13 Observation at 10:56am Room 210 Bed B revealed food and dry substance under the bed, and floor mat/ fall mat with dirt. Further observation of Room 209 Bed B floor with dry drip marks on the floor and spills on wall that are dry. Observation of Room 208 Bed A revealed floor with dry substance. At 11:06am observation of Room 207 floor has dry spills, and brown matter to walls and door. 1e. An observation on 10/20/21 at 9:38 AM of room 356 revealed a fan at resident's bedside table. The fan was observed to have excessive dust build up. At 10:43am observation of Room 115 fan in room with visible dust. 1f. An observation on 10/20/21 at 10:38 am of Room 110's bathroom revealed black substance behind toilet. Further Observation at 10:48am of Room 125's bathroom noted with brown staining to floor around the toilets. At 11:06am in Room 207's bathroom red dry substance to assist bar on raised toilet. 1g. An observation on 10/20/21 at 9:38 AM of room 356 revealed baseboard peeling away from the wall beside bed A. Observation further revealed at 10:45am in Room 132 baseboards separating from floor. Observation of shower Room 127 revealed hole in ceiling, and paint peeling on trim. Interview and observation with the Maintenance Director and Housekeeping Manager on 10/21/21 at 9:20am revealed maintenance concerns were provided by staff and verbally. Staff were to fill out a maintenance request regarding items in the facility that required repair. Regarding maintenance concerns of baseboards and	F 584	New housekeeping manager hired on 11/1/2021. EVS Account Manager educated housekeeping staff on the expectation that all resident rooms, bathrooms, shower rooms are clean and sanitary. This education will be completed by 11/19/2021. NHA educated Maintenance Director and Maintenance Assistant on the expectation that all PTACs filters are clean and sanitary, and baseboards, walls and ceilings are repaired and in good condition. This education was conducted on 11/18/2021. Monitoring: EVS Account Manager or designee will audit 25 rooms per week (to include shower rooms) x 4 weeks, then 20 rooms per week x 4 weeks, then 15 rooms per week x 4 weeks ensuring the cleanliness of resident rooms, bathrooms, and shower rooms. The Maintenance Director or designee will audit 25 rooms per week (to include shower rooms) x 4 weeks, then 20 rooms per week x 4 weeks, then 15 rooms per week x 4 weeks to ensure the PTAC filers are clean, and baseboards, walls and ceilings are in good repair. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is	

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F 584	Continued From page 14 bedrooms of 356 and 132 he was not made aware. He further indicated he was not made aware of maintenance concerns regarding peeling paint, marring to wall and behind residents' beds. Maintenance stated these were concerns he should have been made aware of and were an easy fix. PTAC units were cleaned monthly. The dust observed on the PTAC units was an accumulation of only a month. Housekeeping Manager revealed in the instance housekeeping staff observed maintenance concerns during the process of completing housekeeping duties they were to notify maintenance. Issues regarding cleaning had previously been brought to his attention. As a result, the Housekeeping Manager stated he provided in-service training and spot-checked housekeeping staff performance daily. The brown substance identified on the floors of resident rooms was microfiber from the mops. He revealed the microfiber material should be used on wooden floors. The brown substance identified in bathroom 109 and shower room 127 and was not acceptable and should have been cleaned as housekeeping staff performed daily duties. Resident personal fans were to be cleaned by the resident or the resident's family member. In the instance the resident requested, housekeeping staff to clean their personal fans they would. The housekeeping manager stated the cleanliness of restroom and dried spill to walls was not satisfactory. During Interview and observation with the Administrator 10/21/21 at 10:00am revealed rooms were not acceptable with cleanliness, and it has been an issue they have tried to resolve. The Maintenance Director was new to the building, and he should be provided all	F 584	necessary to maintain compliance.	

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F 584	Continued From page 15 maintenance concerns so they can be repaired timely.	F 584		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not	F 655		12/6/21

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F 655	Continued From page 16 limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop a baseline care plan within 48 hours of admission with measurable objectives and timetables to address wandering behaviors for 1 of 3 residents (Resident #562) reviewed for accidents. The facility also failed to address the immediate needs on the baseline care plan in the areas of dementia care, pressure ulcer, psychotropic medication use, and urinary catheter care for 1 of 2 residents (Resident #57) reviewed for hospice. The findings included: 1. Resident #562 was admitted to the facility on 10/14/21 with diagnoses that included metabolic encephalopathy, Alzheimer's disease, and dementia. The Admission Functional Abilities and Goals Assessment dated 10/14/21 indicated Resident #562 needed some help with self-care activities and functional cognition but was independent with indoor mobility and ambulation. An Elopement Risk Screen dated 10/14/21 indicated Resident #562 was at risk for elopement.	F 655	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. F655 Baseline Care Plan What was done for the resident: Resident#562 Care plan has been updated to reflect the resident□s risk for elopement and behavior of wandering. Resident #57 has been discharged. Identification of other residents: All new admissions to the facility would be at risk for the deficient practice. An audit was conducted by the Minimum Data Set Coordinators (MDS Coordinators) of admissions in the month of October 2021. The audit was completed on or before 11.19.2021. Care plans were updated as deemed necessary.	

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F 655	Continued From page 17 Resident #562's baseline care plan dated 10/14/21 did not address Resident #562's wandering behaviors and elopement risk. The Admission Minimum Data Set (MDS) assessment dated 10/20/21 was in progress and was not completed at the time of the investigation. An interview with Nurse #7 on 10/21/21 at 3:00 PM revealed she admitted Resident #562 into the memory care unit of the facility on 10/14/21 and started her baseline care plan. Nurse #7 stated Resident #562 had wandering and combative behaviors when she was admitted. Nurse #7 also stated she completed Resident #562's elopement risk screen which indicated she was at risk for elopement. Nurse #7 further stated she could not remember if there had been any questions about behaviors when she was completing Resident #562's baseline care plan electronically. Nurse #7 said wandering behaviors and elopement risk should have been addressed in Resident #562's baseline care plan but she was not sure how to add this information. Nurse #7 added that the MDS nurse was responsible for updating the baseline care plans that were initiated at the time of admission. An interview with the Resident Care Specialist (RCS) on 10/21/21 at 11:11 AM revealed she functioned as the MDS nurse and attended the care plan meeting for Resident #562 on 10/18/21 but did not remember discussing her behaviors at the meeting. The RCS stated she was aware that Resident #562 had wandering behaviors upon admission and was at risk for elopement but failed to notice that these areas were not	F 655	Systemic Changes: Education will be provided by the Staff Development Coordinator (SDC) to the facility□s interdisciplinary team (nursing, dietary, social services, therapy, activities) on their role and responsibility in developing a baseline care plan on or before 11.16.2021. Baseline care plans for new admissions will be reviewed by the Interdisciplinary Team for completion as part of the end of day meeting. Monitoring: Director of Nursing/designee will conduct random weekly audits of new admission baseline care plans weekly for 12 weeks. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	

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F 655	Continued From page 18	F 655		

addressed in Resident #562's baseline care plan. The RCS stated she only made sure that baseline care plans were initiated for newly admitted residents but did not check them for accuracy and completeness.

An interview with the Interim Director of Nursing (DON) on 10/21/21 at 3:52 PM revealed Resident #562 had been in the facility for a short time, but she was aware of her wandering behaviors. The DON stated Resident #562's wandering behaviors and elopement risk should have been included in her baseline care plan. The DON was not sure if a question about behaviors was one of the areas that the admitting nurse had to answer when completing the baseline care plan, but she added that the MDS nurse should have updated Resident #562's baseline care plan to address her behaviors.

2. Resident #57 was admitted to the facility on 08/06/21 with diagnoses which included osteomyelitis, urinary retention, sacral pressure ulcer, dementia with delusional episode, depression and Alzheimer's disease. She had an indwelling urinary catheter on admission.

Review of Resident #57's admission Minimum Data Set (MDS) dated 08/12/21 revealed an assessment that noted Resident #57 was cognitively intact.

Record review completed on 10/20/21 at 04:10 PM of Resident #57's initial care plan initiated on 08/06/21 failed to include the indwelling urinary catheter, dementia care, fall risk, antipsychotic and antidepressant medications or pressure ulcer care within 48 hours of admission.

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An interview was conducted regarding baseline care plans with the Minimum Data Set (MDS) assessment Nurse #1 on 10/20/21 at 9:18 AM. She stated the baseline care plan was done on admission and it was part of the ongoing care plan. She stated most of the baseline care plan meetings were held over the phone and they did not email a copy to the resident's family member. She said the meetings usually included the MDS nurse, Social Worker, Therapy and the Business Office Manager. The MDS nurse was asked about important medications being included in the baseline care plan such as antipsychotic medications and she stated eventually they are included in the care plan with the 14 day admission MDS care plan.

An interview with the Social Worker (SW) was done on 10/20/21 at 12:03 PM regarding baseline care plans. She stated the MDS nurse was responsible for care plans. She said the baseline care plan was done by MDS and she was not involved. The SW noted she was present at the 72 hour care conference meetings and the MDS nurse reviewed the baseline care plan in the meeting. The SW stated the medication list was provided to the family if the meeting was in person, or they verbalized it with the family, if it was over the phone.

The Regional Corporate Nurse Director was interviewed on 10/21/21 at 03:35 PM regarding baseline care plans. She said the basic care plans should include the items or areas to care for the Resident's basic needs. She noted the facility admission assessment data set should be utilized and the baseline care plan should be built from that information, along with items such as pressure ulcer care, urinary catheter and other

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F 655	Continued From page 20 areas that staff need to know.	F 655		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, nurse practitioner interview, and physician interview the facility failed to identify, reweigh, and assess significant weight loss in 1 of 8 residents for nutrition (Resident #93). Findings included: Resident #93 was initially admitted on 8/24/2021 and was discharged to the hospital on 8/25/2021. Resident #93 had a readmission date of	F 692	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. F692 Nutrition/Hydration Status	12/6/21

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F 692	Continued From page 21 9/11/2021 with diagnoses that included Alzheimer's disease, renal insufficiency, Parkinson's disease, stroke, and seizures. The admission Minimum Data Set (MDS) dated 9/15/2021 indicated Resident #93 was severely cognitively impaired. On admission, the MDS showed Resident #93 had a weight of 183 pounds. The MDS stated Resident #93 had no weight loss of 5% or more in the past month. Resident #93 received tube feeding. The MDS stated the resident had no natural teeth. Review of Care Plan initiated 9/11/2021 revealed Resident #93 was at risk for decreased nutritional status and dehydration and received diuretic therapy. Interventions put into place included provide tube feeding/water flushes as ordered, monitor weight, and monitor diet tolerance. A review of the physician orders dated 9/11/2021 revealed Resident #93 had a diet order for nothing by mouth and an enteral feed every shift at 38 cubic centimeters (cc)/ hour continuously with 150cc water flush every two hours. A review of the physician orders dated 9/14/2021 revealed give 1 Lasix 20mg (milligram) tablet every day shift for edema for three days. A review of a Physician Progress Note dated 9/20/2021 stated Resident #93 had edema. Orders were written to increase Lasix to 40mg every day and to monitor Resident #93's edema. A review of the physician orders dated 9/21/2021 revealed give 2 Lasix 20mg tablets every day shift for edema.	F 692	Maintenance What was done for the resident: Resident#93 was reweighed on date. The resident□s most current weight has been verified and updated in her medical records. Physician services, dietician and the resident□s responsible party have been notified of the resident□s current weight status. There was no negative outcome as a result of the alleged deficient practice. Identification of other residents: An audit of residents□ weights was conducted by the Director of nursing/designee on or by 11.18.2021. Residents□ identified with significant weight changes of minus or plus 5lbs were verified and added to the focus weight meeting for further monitoring. Systemic Changes: Staff that are responsible for retrieving and monitoring residents□ weights have been educated by Director of nursing/designee regarding retrieving, verifying, documenting, and follow-up of resident weights. This education also included staff roles in the facility□s FOCUS meeting for weights. Resident weights will be reviewed in the FOCUS meeting to identify any changes and or absence of weights. Monitoring: Director of Nursing/designee will conduct random weekly audits of weight focus meeting weekly for 12 weeks.	

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F 692	Continued From page 22 A review of Resident #93's electronic medical record for weights revealed the following data: - 9/11/2021 183 pounds weighed by hydraulic lift scale - 9/20/ 2021 185 pounds weighed by hydraulic lift scale - 9/25/2021 181 pounds weighed by mechanical lift - 10/1/2021 181 pounds weighed by hydraulic lift scale - 10/4/2021 161 pounds weighed by hydraulic lift scale - 10/20/2021 150.5 pounds weighed by hydraulic lift scale On 10/21/2021 the Regional Corporate Nurse Director presented the team with a handwritten log labeled Resident Focused Meeting Log dated 10/8/2021. The Regional Corporate Nurse Director stated the log was found in the former Director of Nursing's office. The log identified 7 residents to include Resident #93. The log revealed Resident #93 had a weight of 161 pounds and a reweigh on 10/8/2021 of 158.0. These written documented weights were not included in the resident's electronic medical record weight log. Observations made throughout the survey on 10/18/2021 through 10/21/2021 revealed external feeding was running at the rate ordered by the physician. The tubing was dated with the current date and a flush bag with water was present. There were no identified concerns. A review of the Registered Dietician's Progress Noted dated 10/20/2021 read in part "meds reviewed include diuretic therapy and per IDT (Interdisciplinary Team) Lasix increased for	F 692	Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	

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edema. Some weight loss considered positive due to high BMI >35 in past; also weight loss related to edema management and potential incorrect weights at admission".

An interview was conducted on 10/20/2021 at 10:33 A. M. with the Restorative Aide #1 revealed at the beginning of each week, the Nursing Supervisor gave her a list of residents who required weights to be collected. Restorative Aide #1 stated she collected each resident's weight and then gave the paper with the weights handwritten to the Unit Manager, who was responsible for entering the weights into the computer. The Restorative Aide #1 stated she did not see Resident #93's weights from previous weeks and was unaware there had been a weight change.

An interview conducted on 10/20/2021 at 11:20 A. M. with the Unit Manager revealed she entered each resident's weight into the resident's electronic medical record from a paper provided to her by the Restorative Aides. When the weights were entered, the computer system sent out an alert for a weight increase or decrease of five pounds from the previous entered weight. The Unit Manager stated she entered the weights for Resident #93 on 10/1/2021 and 10/4/2021. During the interview the Unit Manager stated when the computer alerted her to a weight change for Resident #93, she clicked okay and did not take any action. The Unit Manger indicated she should have completed a reweigh on Resident #93 and then followed up with the physician if the weight change was accurate.

A telephone interview conducted on 10/21/2021 at 9:58 A. M. with Registered Dietetic Technician

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(RDT) revealed tube feed residents were considered at high risk for nutritional complications and were reviewed monthly. The RDT stated on 10/18/2020 she started a review on Resident #93 and noticed a significant weight change from 10/1/2021 to 10/4/2021. The RDT felt the weight entered on 10/4/2020 was an error and requested staff complete a reweigh on the resident. During the interview the RDT stated she had not received the reweigh information by the end of business on 10/18/2021 to complete her review of Resident #93. The RDT left a note for the Registered Dietician to complete the review on 10/21/2021, when the RD arrived at work and staff had reported Resident #93's current weight.

An interview conducted on 10/20/2021 at 10:37 A. M. with the Registered Dietician (RD) revealed she received a note on 10/20/2020, left by the Registered Dietetic Technician (RDT) on 10/18/2020 to evaluated Resident #93 for potential weight loss. The RD stated the DRT did not have time to complete an evaluation on Resident #93 on 10/18/2020. During the interview the RD stated she felt the weight loss from 181 pounds on 10/1/2021 to 161 pounds on 10/4/2021 was inaccurate and she had requested a reweigh to verify. The RD stated nurses should have contacted her for an evaluation when a resident who received tube feedings experienced a weight change. The RD stated she became aware of Resident #93's weight changes today, 10/20/2020, from the RDT and no nurse contacted her about Resident #93's weight loss.

An interview conducted on 10/21/2021 at 1:19 P. M. with Nurse #6 revealed she was familiar with Resident #93 and had provided her care over the last three years. The Nurse stated when Resident

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#93 returned from the hospital in September 2021, she was "full of fluid" and was "very swollen". During the interview Nurse #6 revealed orders were written for Resident #93 to be given Lasix. Nurse #6 stated she was not notified of Resident #93's weight loss. Nurse #6 stated as of today, 10/21/2021, Resident #93 was no longer swollen, and the weight change was probably fluid.

A telephone interview conducted on 10/21/2021 at 11:35 A. M. with the Nurse Practitioner (NP) revealed it took a month from a resident's admission to determine a true baseline weight due to changes in medical conditions and appetites. The NP stated staff did not notify her of a weight change in Resident #93 and had she known she would have requested a reweigh. During the interview the NP stated Resident #93 may have been in fluid overload from her hospitalization or needed an adjustment with her tube feeding. The NP further stated if staff had reweighed Resident #93 and her weight was trending down, she would have closely monitored Resident #93 and contacted the dietician for evaluation.

A telephone interview conducted on 10/20/2021 at 12:15 P. M. with the Medical Director (MD) revealed the staff did not notify him about Resident #93's weight change. The MD further stated he felt the weight on 10/4/2021 was inaccurate. During the interview the MD stated Resident #93 returned from the hospital with +2 edema (3-4 millimeter of indentation when pressed, rebounding in 15 seconds or less). The MD also stated Resident #93's current weights were comparable to her weight from last year's admission. During the interview the MD stated if

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F 692	Continued From page 26 staff had reported Resident #93's weight change to him, he would have requested a reweigh and if the weight had decreased, a plan would be created to address Resident #93's weight loss. The MD stated when he evaluated Resident #93 on 10/18/2021, Resident #93's edema had improved, and she presented with no medical complications. An interview conducted on 10/21/2021 at 4:03 P. M. with the Interim Director of Nursing (DON) revealed a weight change of twenty pounds in three days was considered significant and she expected staff to report a weight change of this amount to the physician and upper management. The DON further stated she was unsure why Resident #93's weight change was not reported.	F 692		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services 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)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.	F 726		12/6/21

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F 726	Continued From page 27 §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to ensure 1 of 4 licensed nurses who worked for the facility through a staffing agency had completed competencies to provide care to residents (Nurse #5). Findings included: Nurse #5 was contracted through a staffing agency to work for the facility with a start date of 8/30/2021. A review of employment forms for Nurse #5 revealed no facility orientation was completed, no mask competency was completed, no hand hygiene competency was completed, no code of conduct was completed, and no COVID testing consent was obtained. Nurse #5 was interviewed on 10/20/2021 at 9:53 PM. Nurse #5 explained she was contracted to work for the facility for 13 weeks, starting 8/31/2021. Nurse #5 reported she had not received any orientation or had any competencies checked at the facility since she started to work for the facility.	F 726	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. F726 Competent Staff What was done for the resident involved: No residents were noted to be affected by the alleged deficient practice. Nurse #5 has not worked at the facility since the dates of the survey. Identify others: An audit was conducted by the Staff Development Coordinator (SDC)/designee on or before 11.22.21 regarding agency staff currently working at the facility to confirm the receipt of appropriate orientation/ training to provide	

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F 726	Continued From page 28 The interim Director of Nursing (DON) was interviewed on 10/21/2021 at 11:01 AM. The DON reported she was not aware Nurse #5 had not had competencies checked when she started to work for the facility. The DON explained the evening shift supervisor was given the paperwork for Nurse #5 to complete on her first shift to work the facility. The DON reported it was her expectation that all agency nurses had competencies completed prior to starting work for the facility. An unsuccessful attempt was made to interview the evening shift nurse. The Administrator was interviewed on 10/21/2021 at 3:57 PM. The Administrator reported the increased turn-over in staff at the facility increased the use of agency nurses to provide resident care and the competencies for Nurse #5 were missed by the evening supervisor. The Administrator reported a process was in place to ensure all agency staff had competencies checked and the process failed. The Administrator reported she expected all agency nurses to have their competencies checked prior to beginning work for the facility.	F 726	care to residents. No other agency staff were noted to be affected. Systemic Changes: The Staffing scheduler and the facility educator were educated by Director of Nursing/designee on or before 11.22.21 regarding the process to ensure that agency staff receive the appropriate facility orientation/training to provide care to residents. Staffing schedules will be reviewed and reconciled daily in morning meetings to identify and validate receipt of orientation for agency staff. Monitoring: Director of Nursing/designee will conduct random weekly audits of the staffing schedules and agency orientation weekly for 12 weeks. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	
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	F 732		12/6/21

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F 732	Continued From page 29 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. §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 reviews and staff interviews, the facility failed to accurately report resident census on 5 of 8 posted nurse staffing sheets and failed to accurately report licensed and unlicensed scheduled staff for 8 of 8 posted nurse staffing sheets. Findings included:	F 732	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the	

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F 732	Continued From page 30 The following posted nurse staffing sheets were reviewed: 9/1/2021, 9/2/2021, 9/13/2021, 9/14/2021, 10/4/2021, 10/8/2021, 10/9/2021, and 10/10/2021. 1. The census for the facility was not reported on the following posted nurse staffing sheets: 9/1/2021, 10/4/2021, 10/8/2021, 10/9/2021, and 10/10/2021. The Scheduler was interviewed on 10/21/2021 at 10:59 AM. The Scheduler reported she created the posted nurse staffing sheet in the morning but did not update during the day. The Scheduler reported she was not aware the census had not been included on the posted nurse staffing sheets. An interview was conducted with the interim Director of Nursing (DON) on 10/21/2021 at 11:01 AM. The DON reported she had not checked the posted nurse staffing sheets for accuracy. 2. The posted nurse staffing sheet dated 9/1/2021 was reviewed. The posted nurse staffing sheet documented 9.5 nursing assistants (NAs) provided 71.25 hours of care for the 2nd shift (3:00 PM to 11:00 PM). The nursing schedule indicated that 8 NAs were scheduled to work 2nd shift on 9/1/2021. The posted nurse staffing sheet dated 9/2/2021 was reviewed. The posted nurse staffing sheet documented 10.5 NAs provided 78.75 hours of care for 2nd shift that date. The nursing schedule indicated that 10 NA were scheduled to work. The posted nurse staffing sheet for 3rd shift (11:00 PM to 7:00 AM) documented 1 Registered	F 732	provisions of federal and state law. F732 Posted Nurse Staffing Information survey. What was done for the resident involved? No residents were affected by the alleged deficient practice. The staffing sheets requested during the survey were corrected. Others identified No residents were identified as being affected by the alleged deficient practice. The Staffing Scheduler and the Staff Development Coordinator (SDC) were educated on or before 11/19/2021 by the DON/Designee on the correct way to complete and update the Staffing Postings. Systemic Change: The staff postings will be reviewed, reconciled, and validated as part of the daily meeting by the staffing coordinator and SDC. Once reviewed and verified the staffing sheets will be signed by the SDC or designee and filed. Weekly for 12 weeks the staffing sheets will be reviewed by the administrator/DON to ensure they have been signed off indicating the sheets have been reviewed prior to being filed. This information will be tracked and trended and presented to the monthly QAPI for 3 months unless determined	

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F 732	Continued From page 31 Nurse (RN) provided 8 hours of care and 2 Licensed Practical Nurses (LPNs) provided 16 hours of care. The nursing schedule indicated 2 RNs and 1 LPN were scheduled to work that date. The posted nurse staffing sheet for 9/13/2021 was reviewed. The posted nurse staffing sheet documented no RN had been scheduled to work on 2nd shift and 8 NAs provided 60 hours of care. The nursing schedule indicated 1 RN and 10.5 NAs were scheduled to work. Furthermore, it was noted 3 NAs worked less than an 8 hour shift that date for 2nd shift, and this was not noted on the posted nurse staffing sheet. The posted nurse staffing sheet for 9/14/2021 documented no RN provided care, 4.5 LPNs provided 37.5 hours of care, and 10.5 NAs provided 78.75 hours of care for 2nd shift that date. The nursing schedule for 9/14/2021 indicated 1 RN worked 4 hours, 4.5 LPNs, and 10 NAs were scheduled to work 2nd shift. The posted nurse staffing sheet documented 7 NAs provided 52.5 hours of care for 3rd shift on 9/14/2021. The nursing schedule indicated 9 NAs were scheduled to work 3rd shift on 9/14/2021. The posted nurse staffing sheet for 10/4/2021 was reviewed. The 1st shift (7:00 AM to 3:00 PM) documented no RN was scheduled to work, and 5 LPNs provided 40 hours of care. The nursing schedule indicated 1 RN worked 1st shift on 10/4/2021 and 4 LPNs were scheduled to work 1st shift on 10/4/2021. The posted nurse staffing sheet for 2nd shift on 10/4/2021 documented 6 LPNs provided 48 hours of care, and 9 NAs provided 67.5 hours of care. The nursing schedule for 2nd shift on 10/4/2021 indicated 5	F 732	otherwise by the QAPI committee.	

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LPNs and 7.5 NAs were scheduled to work.

The posted nurse staffing sheet dated 10/8/2021 was reviewed and it documented 6 LPNs provided 48 hours of care and 10 NAs provided 75 hours of care on 1st shift. The nursing schedule indicated 5 LPNs and 11 NAs were scheduled to work 1st shift that date. The posted nurse staffing sheet documented 1.5 RNs provided 12 hours of care, 3.5 LPNs provided 28 hours of care and 10 NAs provided 75 hours of care for 2nd shift that 10/8/2021. The nursing schedule indicated 1 RN, 4 LPN, and 9 NAs were scheduled to work 2nd shift on 10/8/2021. Furthermore, the nursing schedule indicated 1 NA left early from the 2nd shift and this was not noted on the posted nurse staffing sheet. The posted nurse staffing sheet documented 1 LPN provided 8 hours of care for 3rd shift on 10/8/2021. The nursing schedule indicated 2 LPNs were scheduled to work 3rd shift that date.

The posted nurse staffing sheet dated 10/9/2021 was reviewed and it documented 11 NAs provided 82.5 hours of care on 2nd shift. The nursing schedule for 10/9/2021 indicated 1 NA arrived late and left early for 2nd shift on 10/9/2021.

The posted nurse staffing sheet dated 10/10/2021 was reviewed and it documented 11 NAs provided 82.5 hours of care for 1st shift that date. The nursing schedule indicated 10 NAs were scheduled to work 1st shift that date. The posted nurse staffing sheet documented 12 NAs provided 90 hours of care on 10/10/2021 for 2nd shift. The nursing schedule indicated 11 NAs were scheduled to work 2nd shift that date. The posted nurse staffing sheet documented 1 RN

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F 732	Continued From page 33 provided 8 hours of care and 2 LPNs provided 16 hours of care for 3rd shift on 10/10/2021. The nursing schedule indicated 2 RNs and 1 LPN were scheduled to work 3rd shift that date. The Scheduler was interviewed on 10/21/2021 at 10:59 AM. The Scheduler reported she created the posted nurse staffing sheet in the morning. The Scheduler reported she did not update the posted nurse staffing sheet during the day and did not correct the posted hours when staffing adjustments were made. The Scheduler reported she was not aware she needed to adjust the posted nurse staffing. An interview was conducted with the interim Director of Nursing (DON) on 10/21/2021 at 11:01 AM. The DON reported she had not checked the posted nurse staffing sheets for accuracy and had not checked the posted nurse staffing sheets against the nursing schedule. The Administrator was interviewed on 10/21/2021 at 3:57 PM. The Administrator reported the facility had staffing issues due to the COVID-19 pandemic and they had difficulty covering the shifts with nursing and NA staff. The Administrator reported she thought the scheduler was not able to update the posted nurse staffing sheet with changes. The Administrator reported it was her expectation the posted nurse staffing sheet was accurate and reflected the nursing and NA hours.	F 732		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		12/6/21

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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 812	Continued From page 34 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to discard expired food available for use in 1 of 1 walk-in cooler in the kitchen, and failed to label, and date prepared food and discard expired food available for use in 2 of 5 nourishment refrigerators (300 west and 100 hall). The findings included: 1. During the initial tour of the kitchen on 10/18/21 from 10:20 AM to 10:50 AM with the Dietary Manager (DM), an observation of the walk-in cooler revealed 2 unopened and 1 opened gallon containers of small curd cottage cheese marked with an expiration date of 10/14/21. The DM grabbed all three containers out of the walk-in cooler and discarded them into the trash can. The DM stated the expired containers of cottage cheese should have been	F 812	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. F812 Food Procurement, Store/Prepare/Serve-Sanitary What was done for the resident involved? No residents were identified to be affected by the alleged deficient practice. The expired food in the walk-in cooler was discarded on 10/18/2021. The sandwich in the 300 west nourishment room refrigerator was discarded on 10/21/2021.	

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F 812	Continued From page 35 discarded when they had expired on 10/14/21. An interview with the DM on 10/18/21 at 10:45 AM revealed they had not served cottage cheese within the last two weeks and the expired cottage cheese had gotten overlooked because none of the residents ordered it. The DM stated when the food supplies came in and they received their food truck delivery order, they usually rotated the items in the walk-in cooler. She also stated the expired cottage cheese was missed because she stopped ordering it, so it was just sitting in the refrigerator. The DM said she tried to check the food items in the refrigerators every Monday, but she hadn't gotten around to doing it yet. 2. An observation of the 300 west nourishment refrigerator on 10/21/21 at 8:30 AM with the Dietary Manager (DM) revealed an unlabeled and undated sandwich in a take-out box that was stored on one of the shelves. The DM stated it should have dated and labeled when it was placed inside the refrigerator. 3. An observation of the 100 hall nourishment refrigerator on 10/21/21 at 8:40 AM with the DM revealed a prepared vanilla pudding dated 10/16/21 with a discard date of 10/19/21, a corn dog in an unlabeled and undated plastic bag and an unlabeled and undated left-over food in a take-out box were stored inside the refrigerator. The DM stated the vanilla pudding should have been discarded on 10/19/21 and both unlabeled food items should have been dated and labeled with the resident's name. An interview with the Dietary Manager (DM) on 10/21/21 at 8:45 AM revealed she tried to check the nourishment refrigerators when she did her	F 812	The food items in the 100-hall nourishment room were discarded on 10/21/2021. The Dietary Manger was re-educated by the Registered Dietician/designee on or before 11.23.2021 regarding ensuring foods are properly stored and labeled. Identification of other residents: All residents are at risk for the deficient practice. An audit of kitchen and nourishment room refrigerators was conducted by Administrator on or before 11/18/2021. No other refrigerators or freezers were noted to be affected. Systemic change: The Administrator/ Registered Dietician/Dietician assistant educated all staff to include the Dietary Manager and Dietary staff regarding labeling and dating opened items and discarding expired foods. This education will be completed on or before 12/01/2021. Dietary Manager or designee will do daily rounds of the kitchen and nourishment room refrigerators to ensure that expired foods are not stored and that foods are labeled and dated. Monitoring: The Administrator/designee will conduct random weekly audits of the kitchen and nourishment room refrigerators and freezers weekly for 12 weeks. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the	

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F 812	Continued From page 36 rounds every morning, but she had been busy in the kitchen that she forgot about checking the nourishment refrigerators when the state survey had started this week. An interview with the Administrator on 10/21/21 at 4:33 PM revealed her staff had been trained to label and date any food item stored in the nourishment refrigerators and they should have discarded all expired food items in the walk-in cooler and the nourishment refrigerators.	F 812	Administrator monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of	F 849		12/6/21

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the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:
(A) The services the hospice will provide.
(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.
(C) The services the LTC facility will continue to provide based on each resident's plan of care.
(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.
(E) A provision that the LTC facility immediately notifies the hospice about the following:
(1) A significant change in the resident's physical, mental, social, or emotional status.
(2) Clinical complications that suggest a need to alter the plan of care.
(3) A need to transfer the resident from the facility for any condition.
(4) The resident's death.
(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.
(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.
(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical

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direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.
(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.
(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State

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scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.
The designated interdisciplinary team member is responsible for the following:
(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.
(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.
(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.
(iv) Obtaining the following information from the hospice:
(A) The most recent hospice plan of care specific to each patient.
(B) Hospice election form.
(C) Physician certification and recertification of the terminal illness specific to each patient.
(D) Names and contact information for hospice personnel involved in hospice care of each patient.
(E) Instructions on how to access the hospice's 24-hour on-call system.
(F) Hospice medication information specific to each patient.
(G) Hospice physician and attending physician (if any) orders specific to each patient.
(v) Ensuring that the LTC facility staff provides

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F 849	Continued From page 40 orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on record review, staff and Nurse Practitioner interviews, the facility failed obtain a Hospice referral as ordered by the physician for a resident at end of life for 1 of 2 residents reviewed for Hospice (Resident #57). The findings included: Resident #57 was admitted to the facility on 08/06/21 with diagnoses which included osteomyelitis, sacral pressure ulcer and Alzheimer's disease. Resident #57's care plan initiated on 08/09/21 noted the focus area for Advance Directive was Do Not Resuscitate (DNR). Review of Resident #57's admission Minimum Data Set (MDS) dated 08/12/21 revealed an assessment that noted Resident #57 was cognitively intact. Record review of a nursing progress note from Nurse #1 on 10/13/21 at 01:41 PM regarding	F 849	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. F849 Hospice Services Corrective action for the resident involved? Resident #57 has been discharged. How to identify other residents at risk? An audit was conducted by the Director of Social Services/designee on or before 11.23.2021 of current Hospice residents to review timeliness of referral process. No other residents were noted to be affected.	

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F 849	Continued From page 41 hospice services revealed she had spoken with the family member about the resident and the family had agreed to have hospice services for her. The Nurse Practitioner (NP) was notified. Attempts were made to contact Nurse #1 without success. Review of Resident #57's physician orders revealed a request written on 10/13/21 by the NP for a hospice referral. Review of Resident #57's hospice referral written on 10/13/21 revealed hospice had not been contacted. Resident #57 was observed on 10/18/21 at 11:47 AM resting in bed and she was tilted on her right side. She had two drinks at the bedside. Resident #57 was interviewed on 10/18/21 at 11:47 AM and she denied having any pain. She noted they were taking good care of her. An observation was done on 10/18/21 at 03:14 PM of Resident #57. She was resting on her side and no grimacing or discomfort was noted. Resident #57 was interviewed on 10/19/21 at 10:42 AM and stated she was comfortable and denied pain. An observation was done on 10/20/21 at 10:30 AM of Resident #57 being comforted by Nurse Aide (NA) #1 who was stroking her hand. NA #1 was interviewed on 10/20/21 at 10:32 AM regarding Resident #57. She stated they had not been able to obtain her blood pressure after	F 849	Systemic change: The referral process for hospice services was reviewed by the Social Service Director/designee with the Interdisciplinary team on or before 12.01.2021. The referral process review included who to notify for referrals in the absence of the social worker director. Hospice referrals will also be discussed in the facility□s daily morning and afternoon meetings. Monitoring: The Director of Nursing/designee will conduct random weekly audits of Hospice referrals weekly for 12 weeks. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	

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multiple attempts that morning and that her family had been called.

Nurse #2 who was caring for Resident #57 was interviewed on 10/20/21 at 10:42 AM. She noted the resident's condition had changed and she had alerted the NP, that was present on the unit. The nurse stated the resident was less alert, had difficulty swallowing her medications today, was moaning at times and had not eaten breakfast. Her family had asked that she be kept comfortable and said they were on their way.

Record review of the 10/01/21-10/19/21 Medication Administration Record revealed she had been assessed for pain on each day, evening and night shift and her pain score was listed as 0, with one exception on dayshift 10/9/21 it was a 5. This was on a pain scale of 0-10 with 0 indicating no pain and 10 severe pain. On evening shift 10/09/21 it was noted her pain was 0.

The Administrator was interviewed on 10/20/21 at 11:39 AM and stated she had been covering for the Social Worker (SW) for two weeks, which including 10/13/21 thru 10/18/21 when the SW returned to the facility. The administrator stated she had not been made aware of the referral to hospice for Resident #57 on 10/13/21 or she would have called or faxed the order to the hospice agency. The Administrator was asked what the usual process for hospice contact was and she stated she was not sure. (I don't have exact date she started covering SW but I know for sure it was from date of consult on 10/13/21 till 10/18/21)

Nurse #2 was interviewed on 10/20/21 at 11:57 AM regarding hospice orders. She stated if orders

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were put in for hospice, the nurse would let the SW know and the SW always handled it. She noted she was not sure why hospice had not been notified for Resident #57.

An interview was done on 10/20/21 at 11:47 AM with the interim Director of Nursing (DON) regarding hospice referrals. She stated the social worker usually handled the hospice consults, and if the SW was not here, she was not sure of the process, but there should not be a delay.

The Social Worker was interviewed on 10/20/21 at 12:03 PM regarding the hospice referral for Resident #57. She stated the process once a referral was ordered, was that the nurses communicated to her in the electronic record or would come tell her directly. She stated when she was not there, some nurses would take the lead and notified hospice, or they would tell the person covering for the SW. She stated she was made aware of Resident #57's referral yesterday 10/19/21 and sent the information today 10/20/21.

Record review indicated the NP had ordered 3 medications on 10/20/21 to be used as needed for end of life comfort care for Resident #57. These included Atropine drops as needed for increased secretions, morphine as needed for pain and lorazepam as needed for anxiety. The 3 medications were not available at the facility and they were waiting on the medications when Resident #57 passed shortly after 1:00 PM.

A phone interview was conducted on 10/20/21 at 04:55 PM with the Hospice Coordinator. She stated she had received the hospice referral information today for Resident #57, but the resident had already passed when they contacted

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F 849	Continued From page 44 the facility. The coordinator said hospice had reached out to the family in the afternoon. The Nurse Practitioner was interviewed on 10/21/21 at 11:25 AM about the hospice consult for Resident #57. She stated it varied on how long it took for hospice services to be started and she had seen it take 3 days. She was asked if Resident #57 had suffered, as a result of the missed hospice consult. She stated she believed the care that was needed was given. The NP noted she had assessed her right after she ordered the medications for secretions, pain and anxiety and she was moaning at that point. A follow-up interview was done with the Administrator on 10/21/21 at 10:57 AM regarding hospice services for Resident #57. She said it was a communication error. She noted Nurse #2 followed through on the consult this week and had made the SW aware of the consult on 10/19/21. The Regional Nurse Director was interviewed on 10/21/21 at 03:35 PM regarding hospice services. The Regional Director stated she would expect the hospice order to be sent once the family was notified.	F 849		
F 880 SS=F	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.	F 880		12/6/21

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F 880	Continued From page 45 §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: (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	F 880		

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F 880	Continued From page 46 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, staff interviews and the high level of transmission for COVID-19 in the county, the facility failed to screen facility surveyors and visitors for signs and symptoms of COVID-19 before entering the facility 4 of 4 on-site survey days and 1 of 1 nurse (Nurse #4) was observed administering a gastrostomy tube feeding nutritional bolus to Resident #17 without gloves. Additionally, the facility failed to revise their infection control policies and implement the Centers for Disease Control and Prevention (CDC) guidelines for the use of Personal Protective Equipment (PPE) when 5 of 5 staff members (Nurse Aide #1, Nurse #4, Nurse Aide #3, Nurse Aide #2 and Nurse #2) in the general halls failed to wear eye protection while providing care to 6 of 6 residents (Resident #47, Resident #562, Resident #45, Resident #65, Resident #88 and Resident #37) reviewed for	F 880	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. F880 Infection Control In review of the F880 deficiency related to COVID-19 screening of visitors and vendors. On 11/9/21 the center employed the 5 whys Method of Root Cause analysis and determined the following to be the root cause: Staff were not properly educated	

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F 880	Continued From page 47 infection control. These failures occurred during a COVID-19 pandemic. Findings included: 1. The facility COVID-19 visitor/vendor screening log form (no date) was reviewed and included in the form was the entrance time, the exit time, a yes/no section for performing hand hygiene, name, phone number, temperature, yes/no section for fully vaccinated and the following symptoms: diarrhea, cough, sore throat, new onset of shortness of breath or difficulty breathing, chills or repeat shaking with chills, muscle pain, headache, new loss of taste or smell, recently traveled out of the US and a section for the screener's initials. The visitor/vender screening log for 10/18/2021 through 10/21/2021 were reviewed. The screening questions for all surveyors and visitors included the entrance time, the name of the surveyor or visitor, the temperature, the yes/no question related to vaccination status was answered, and each surveyor/visitor screening included the screener's initials. None of the screening questions related to the symptoms of COVID-19 were answered and the yes/no answers for each question were struck through for all visitors entering the facility on those dates. The facility entrance was observed 10/18/2021 at 10:00 AM. Six surveyors had their name taken and their temperature checked by Screener #3. Screener #3 asked each surveyor if they were vaccinated. Screener #3 asked "do you have symptoms" of COVID-19 to the group of surveyors.	F 880	on the screening process. The center has resolved this issue by providing re-education to staff. No residents were identified as being affected by this deficient practice. From October 28th to December 6th. The RN Infection Prevention Officer (IPCO) and or the RN Staff Developer (SDC)/designee will provide ongoing education to Department managers, direct care staff and administrative office staff on the screening process for visitors and vendors. The RN IPCO will complete weekly audits for 12 weeks of the visitor/ vendor screening logs and complete weekly screening observations of the screening process x□s 12 weeks and document the results. The RN IPCO will report the results of the weekly audits to the QAPI committee members monthly X 3 months and as needed thereafter. In review of the F880 deficiency related to enteral feeding via gastrostomy tube without gloves. On 11/9/21 the center employed the 5 whys Method of Root Cause analysis and determined the following to be the root cause: Nurse #4 is a new graduate nurse and has been employed in the center approximately 20 days when the survey occurred. Nurse#4 did not initially recognize the need for gloves when	

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F 880	Continued From page 48 The entrance to the facility was observed on 10/19/2021 at 8:34 AM. One surveyor and one visitor were asked if they had been vaccinated against COVID-19 and their temperature was checked. Screener #3 did not ask questions related to symptoms of COVID-19 to the visitor or the surveyor. The entrance to the facility was observed on 10/20/2021 at 8:05 AM. Screener #1 took the surveyor's temperature and asked about vaccination status. Screener #1 did not ask questions related to symptoms of COVID-19 to the surveyor. The entrance to the facility was observed on 10/21/2021 at 8:02 AM. Screener #1 took the surveyor's temperature and asked about vaccination status. Screener #1 did not ask questions related to symptoms of COVID-19 to the surveyor. An interview was conducted with Screener #1 on 10/21/2021 at 8:05 AM. Screener #1 reported she worked as the receptionist for the facility, and she screened visitors prior to permitting them entrance into the facility. Screener #1 reported she asked if the visitor was vaccinated, took their temperature, and documented their temperature, the time they entered, their name, and the name of the resident they were visiting. Screener #1 reported she was trained by Screener #3 but could not remember the date. Screener #1 reported she was instructed to complete the screening log and she had not been trained to ask questions about the symptoms of COVID-19 prior to allowing visitors entry into the facility. Screener #1 reported she did not know when the symptom yes/no answers had been struck	F 880	coming in contact with the gastrostomy tube as a possible portal of entry for infection. Review on 10/27/21 of other residents with enteral feedings and did not identify any residents affected. From October 28th to December 6th. The RN Infection Prevention Officer (IPCO) and the RN Staff Developer (SDC)/designee, will provide ongoing education for licensed nurses to include, general infection control P&P, use of gloves when administering medications via gastrostomy tube, Hand Hygiene and glove use using the World Health Organizations 5 Moments. The RN SDC and RN IPCO will complete weekly audits x□s 12weeks with observations related to hand hygiene and enteral feeding and document the results. The RN IPCO will report the results of weekly audits to the QAPI meeting monthly X3 months and as needed thereafter. In review of the F880 deficiency related to CDC recommendation for eye protection based on county transmission rate. On 11/9/21 the center employed the 5 whys Method of Root Cause analysis and determined the following to be the root cause: The new guidance had not been completely implemented within the center because it was perceived by the administrator as a recommendation and	

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F 880	Continued From page 49 through. Screener #2 was interviewed on 10/26/2021 at 10:34 AM. Screener #2 reported she had trained Screener #3 to perform the COVID-19 visitor screenings. Screener #2 reported she left the facility 7/31/2021, and before her last day, Screener #3 was taught how to check the temperature of visitors and ask each of the symptom questions. Screener #2 reported she and Screener #3 performed the screenings on visitors and she remembered Screener #3 asking the visitors questions about symptoms of COVID-19. Screener #2 reported the yes/no questions related to the symptoms of COVID-19 had not been struck out when she was performing visitor screenings. Screener #3 was interviewed on 10/26/2021 at 10:46 AM. Screener #3 reported she was the Business Office Coordinator and assisted to screen visitors. Screener #3 reported she did not know when the answers to the symptoms of COVID-19 were marked out. Screener #3 reported she remembered asking surveyors on 10/18/2021 if they "had any symptoms" of COVID-19. When Screener #3 was asked why she had not asked about each symptom of COVID-19 on 10/18 and 19/2021, Screener #3 was unable to answer. The interim Director of Nursing (DON) and the Infection Control nurse were interviewed on 10/21/2021 at 11:12 AM. The DON and the Infection Control nurse reported they were not aware the COVID-19 screening questions had been struck through on the visitor/vender screening log and they were not aware the screener was not asking questions related to the	F 880	not a mandate by CMS or a regulatory entity. The guidance has since been implemented. No staff or residents were identified as affected by this deficient practice. On 10/27/21, new PPE guidelines were implemented in the center to reflect the updated eye protection as recommended by the CDC. From 10/27/21 □ 11/19/21, The RN IPCO and RN SDC have educated the center staff of the CDC recommendation regarding eye protection based on county transmission rate and implemented the recommended PPE. The RN IPCO will complete weekly audits x□s 12 weeks and observations of PPE compliance based on regularly checking the CDC database of county transmission rates and document the results. The RN IPCO will report the results of weekly audits to the QAPI meeting monthly X3 months and as needed thereafter.	

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symptoms of COVID-19. The DON reported the visitor screening logs were not reviewed by her or by the Infection Control nurse.

The Corporate Infection Preventionist (IP) was interviewed on 10/22/2021 at 2:05 PM. The IP reported she was responsible for sending out guidance to all facilities in the corporation related to COVID-19. The IP stated she had updated the screening log on 5/17/2021 and it included the symptoms of COVID-19, including diarrhea, cough, sore throat, new onset of shortness of breath or difficulty breathing, chills or repeat shaking with chills, muscle pain, headache, new loss of taste or smell, recently traveled out of the US. The IP reported she was not aware that the Screeners were not asking about symptoms of COVID-19 of visitors prior to allowing entrance to the facility. The IP reported it was her expectation that the screening form was used to identify visitors with signs and symptoms of COVID-19 and prevent those visitors from entering the facility.

2. Resident #17 was observed on 10/18/2021 at 3:27 PM with Nurse #4 administering gastrostomy tube bolus feeding. Nurse #4 was not wearing gloves during the administration of the bolus feed. Nurse #4 stated, "Resident #17 told me he didn't like for me to wear gloves."

An attempt to interview Resident #17 was made during the observation. Resident #17 was not able to answer the interview questions due to his cognition.

Nurse #4 was interviewed again on 10/18/2021 at 3:39 PM. Nurse #4 reported that last week she had given Resident #17 his bolus of nutrition into

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his gastrostomy tube and he pushed her hands away and told her he didn't like the gloves. Nurse #4 reported she should have used gloves during the administration of the bolus nutrition.

The interim Director of Nursing (DON) was interviewed on 10/21/2021 at 3:50 PM. The DON reported she was not aware that Nurse #4 administered the bolus nutrition to Resident #17 without gloves. The DON reported gloves should be used by nursing staff for all resident care and she expected all staff to wear gloves during resident care.

The Administrator was interviewed on 10/21/2021 at 3:57 PM. The Administrator reported she was not certain why Nurse #4 would have administered the bolus nutrition to Resident #17 without gloves. The Administrator reported she expected nursing staff to wear gloves when administering nutrition by a gastrostomy tube.

3. A review of the Centers for Disease Control and Prevention (CDC) COVID-19 Data Tracker on 10/18/21, 10/19/21 and 10/20/21 indicated that the county where the facility was located had a high level of community transmission for COVID-19.

The CDC guidance entitled, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic," updated on 9/10/21 indicated the following information under the section "Implement Universal Use of Personal Protective Equipment for HCP (Healthcare Personnel):
*If SARS-CoV-2 infection is not suspected in a patient presenting for care (based on symptom

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and exposure history), HCP working in facilities located in counties with substantial or high transmission should also use PPE (Personal Protective Equipment) as described below including: Eye protection (i.e., goggles or a face shield that covers the front and sides of the face) should be worn during all patient care encounters.

A review of the facility policy entitled, "COVID-19 Guidance on PPE," revised on 8/16/21 indicated face shields should be worn:
* When working on the OIU (Observation Intake Unit) or COVID units
* When administering aerosol-generating procedures (e.g., nebulizers)
* By non-vaccinated HCP (healthcare personnel) while assisting residents with dining or meal service during communal dining
* During COVID testing of residents or staff
* During screening of staff or visitors entering the center
* Face shields may be universally worn in COVID units, discarded whenever doffed (removed to leave unit or breaks) and replaced with a new face shield. Hand sanitize before and after donning/doffing.
* Face shields may be universally worn in OIU units, discarded whenever doffed (removed to leave unit or breaks) - hand sanitize before and after donning/doffing.

The facility policy entitled, "Enhanced PPE Guidance - Unvaccinated Staff Members," dated 9/20/21 indicated: Unvaccinated staff are required to wear N95 and eye protection (face shields preferred) at all times while in the center, with the exception of break areas where they must observe social distancing.

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a. Nurse Aide (NA) #2 was observed on 10/18/21 at 11:28 AM while she assisted Resident #47 to reposition in bed. NA #2 was wearing a KN95 mask and no eye protection.

A phone interview with NA #2 on 10/21/21 at 11:42 AM revealed she had been told she could wear a surgical mask while providing care to residents because she was fully vaccinated but she preferred to wear a KN95 mask because she felt more protected with a KN95 mask on. NA #2 stated she also did not need to wear eye protection when providing care to residents and that only the unvaccinated staff members were required to wear a face shield and an N95 mask.

b. An observation was made on 10/18/21 at 12:16 PM of Nurse #8 while assisting Resident #562 to sit at a table in the dining room so she could eat her lunch meal. Nurse #8 was wearing a surgical mask with no eye protective gear on while talking to Resident #562 within six-feet distance.

An interview with Nurse #8 on 10/21/21 at 8:50 AM revealed she wore a surgical mask with no eye protection because she had been told that fully vaccinated staff members could wear a surgical mask and that they no longer needed to wear eye protection while providing care to their residents. Nurse #8 stated that unvaccinated staff members were supposed to wear an N95 mask and either face shield or goggles.

c. Nurse Aide (NA) #4 was observed on 10/19/21 at 2:26 PM in Resident #45's room after she transferred her back into bed. NA #4 was wearing a surgical mask with no eye protective gear on.

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An interview with NA #4 on 10/21/21 at 8:55 AM revealed she had been told that fully vaccinated staff members did not need to wear eye protection, so she only wore a surgical mask while she provided care to her residents. She only had to wear eye protection in addition to an N95 mask when working with a resident on enhanced precautions.

d. An observation on 10/20/21 at 9:01 AM was made of Nurse Aide (NA) #3 while she provided incontinence care to Resident #65 who was on contact precautions. NA #3 was wearing a surgical mask with no eye protective gear on. She put on a gown and gloves prior to entering the room and removed both the gown and gloves before leaving the room and washed her hands.

An interview with NA #3 on 10/21/21 at 8:50 AM revealed eye protection was not needed during incontinence care on Resident #65. NA #3 stated she was unvaccinated and was told the day before that she was supposed to start wearing eye protection when providing care to residents, but she forgot and had left her goggles inside her bag.

e. Nurse #6 was observed on 10/20/21 at 9:28 AM administer medications to Resident #88. Nurse #6 was wearing a KN95 mask with no eye protective gear on. On 10/20/21 at 9:33 AM, Nurse #6 went into Resident #37's room and started his nebulizer treatment. Nurse #6 was wearing a KN95 mask with no eye protective gear on.

An interview with Nurse #6 on 10/20/21 at 9:42 AM revealed she was not required to wear eye

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F 880	Continued From page 55 protection while providing care to residents because she was fully vaccinated. An interview with the Interim Director of Nursing (DON) on 10/21/21 at 3:52 PM revealed the facility's current policy was for vaccinated staff members to wear a surgical mask with no eye protection and unvaccinated staff members to wear an N95 mask and goggles or face shield while providing care to residents. The DON stated they were currently working on changing their PPE policy, but it hadn't gone into effect yet. An interview with the Administrator on 10/21/21 at 4:33 PM revealed they were not required to follow the current CDC guidance regarding eye protection use by all staff members while providing care to residents because it was just a recommendation from CDC and not a requirement. The Administrator stated use of eye protection by all staff members was not part of their policy and were only being used by staff members working with residents on enhanced precautions or unvaccinated staff members.	F 880		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically	F 883		12/6/21

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contraindicated or the resident has already been immunized during this time period;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-
(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the

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F 883	Continued From page 57 pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and review of the facility policy, the facility failed to administer and offer the pneumococcal vaccine to 2 of 5 sampled residents reviewed for immunizations (resident #65 and #81). Findings included: 1. Resident #65 was admitted to the facility 10/23/2020 with diagnoses to include heart failure and kidney disease. The most recent annual Minimum Data Set assessment dated 8/20/2021 assessed Resident #65 to be severely cognitively impaired. The MDS documented the pneumococcal vaccine was not offered to Resident #65. A review of the medical record for Resident #65 revealed a "Consent to administer pneumococcal (PCV13 and/or PPSV23) vaccine. The form was dated 10/22/2020 and signed by the resident representative and the option "Yes, I wish to receive the Pneumococcal (PPSV23) vaccine if indicated" was selected. The immunization record for Resident #65 was reviewed and no PPSV23 vaccine was documented as given. The pharmacy progress notes for Resident #65 were reviewed and a note dated 9/21/2021 documented the pharmacist recommendations to administer the PPSV23 vaccine.	F 883	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. F883 Influenza and Pneumococcal Immunizations Correction for the affected resident: Residents #65 and #81 responsible parties have been contacted for consent of pneumococcal and if consented both will receive the pneumococcal vaccination by Friday, November 19, 2021. How to correct it for others who are at risk: An audit of resident pneumococcal immunization records was conducted the Infection Control Preventionist/Director of Nursing/designee on or before 11.18.2021. Residents noted to not have declined or consented the pneumococcal vaccine were identified. Those that consent will receive the immunization on or by November 23, 2021. Systemic Changes: The responsibility for tracking of consent	

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	345254	A. BUILDING _____ B. WING _____	C 10/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 883	Continued From page 58 The interim Director of Nursing (DON) was interviewed 10/21/2021 at 11:12 AM. The DON reported Resident #65 was identified as needing the PPSV23 vaccine by the pharmacist during a chart audit on 9/21/2021. The DON reported the facility was scheduling the PPSV23 vaccine for Resident #65. The DON reported did not know why the PPSV23 vaccine was not given to Resident #65 on 10/23/2020 when the consent was signed. The Infection Control nurse (IP) was interviewed on 10/21/2021 at 11:21 AM. The IP reported she had been at the facility for 3 weeks and she did not know why the PPSV23 vaccine was not given to Resident #65 on 10/22/2020. The IP reported it was her expectation that vaccines were administered to those residents who request vaccines. The Administrator was interviewed on 10/21/2021 at 3:57 PM. The Administrator reported it was her expectation that vaccines were administered as the pharmacy recommended or the resident requested. 2. The facility policy titled Infection Control revised 10/2018 read in part, "Policies and procedures for immunization include the following: obtaining direct and proxy consent." Resident #81 was admitted to the facility on 09/01/21. The admission Minimum Data Set (MDS) assessment dated 09/08/21 indicated Resident #81 had severe cognitive impairment. The MDS revealed the pneumococcal vaccine had not been offered to Resident #81. The MDS documentation	F 883	and or declination of immunizations has been removed from that of the floor nurses and now will be the responsibility of the infection control preventionist (IPCO). In his or her absence it will be the responsibility of the Staff Development Coordinator (SDC). The IPCO and SDC have been educated the Director of Nursing/Designee on or before 11.23.2021 regarding the immunization tracking process. Monitoring: The IPCO/SDC will conduct random weekly audits of immunizations weekly for 12 weeks. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the IPCO/SDC monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	

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F 883	Continued From page 59 indicated the reason why the pneumococcal vaccine was not offered to Resident #81 was because Resident #81 had not been assessed for the pneumococcal vaccine. Review of Resident #81's immunization record revealed no documentation of pneumococcal vaccine consent or refusal. An interview with the acting Director of Nursing (DON) was conducted on 10/21/21 at 11:12 AM and at 3:03 PM. During the interviews she revealed she was the Infection Prevention Nurse until three weeks ago. She further indicated Resident #81 had not been offered or received the pneumococcal vaccine because Resident #81 had been recently admitted to the facility. An interview with the Administrator on 10/21/21 was conducted at 3:57 PM. She revealed the pneumococcal vaccines should be given as indicated per the pharmacy recommendations.	F 883		
F 886 SS=F	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency;	F 886		12/6/21

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F 886	Continued From page 60	F 886		

(ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility;
(iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19;
(iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county;
(v) The response time for test results; and
(vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19.

§483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests;

§483.80 (h)((3) For each instance of testing:
(i) Document that testing was completed and the results of each staff test; and
(ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test.

§483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19.

§483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who

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F 886	Continued From page 61 refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and interviews with agency staff, the facility failed to ensure 3 of 3 agency staff were tested per the facility's COVID-19 Testing Guidelines and the Centers for Medicare and Medicaid Services (CMS) guidelines which indicated testing during outbreak status should be conducted every 3 to 7 days until staff and residents test were negative for 14 consecutive days. Findings included: A review of the facility's COIVD-19 testing Guidelines dated 09/13/21 indicated during outbreak (any single new infection in staff or residents) all staff and residents would be tested when newly identified COVID-19 positive staff or residents were unable to identify close contacts. Staff and residents who tested negative would be tested every 3 to 7 days until testing did not identify any new cases for at least 14 days. A review of the facility COVID-19 tracking document revealed the facility was in outbreak status from 08/24/21 - 10/18/21. Close contacts were not identified and facility wide- testing was implemented on 08/24/21 when a staff member tested positive COVID-19.	F 886	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. F886 COVID-19 Testing-Residents & Staff Correction for the resident involved: There was no resident indicated in the alleged deficient practice. Nurse#1, Nurse#2 and Nurse#3 have received testing according to the facility□s testing guidelines. Correction for other residents at risk for the same deficient practice: An audit was conducted by the Infection Control Preventionist/Staff Development Coordinator o or before 11.23.2021 of agency staff to ensure testing per facility testing guidelines. Those identified have received testing per facility testing guidelines.	

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F 886	Continued From page 62 A review of agency staff records revealed Agency Staff #1 was hired on 08/30/21. The records revealed Agency Staff #1 was not tested for COVID-19 every 3 to 7 days during the facility outbreak status the weeks of 09/20/21, 09/28/21, and 10/11/21. The records revealed Agency Staff #2 was hired on 09/06/21. The records indicated Agency Staff #2 had not been tested every 3 to 7 days for COVID-19 the weeks of 09/05/21, 09/12/21, and 09/20/21. The records revealed Agency Staff #3 was hired on 09/09/21. The record indicated Agency Staff #3 was not COVID-19 tested every 3 to 7 days the weeks of 09/20/21 and 09/27/21. An interview with Agency Staff #1 was conducted on 10/20/21 at 9:53 PM. Agency Staff #1 revealed she was hired around 08/29/21. She revealed she did not have a COVID-19 test until after she had worked in the facility for three weeks. Interview with the Infection Prevention Nurse was conducted on 10/21/21 at 10:00 AM. She revealed she took on the role as Infection Prevention Nurse three weeks ago. She revealed the facility was in outbreak status and facility wide testing had been implemented. She stated all staff should be tested every 3 to 7 days. An interview with the Director of Nursing (DON) was conducted on 10/21/21 at 11:12 AM. She revealed she was the Infection Prevention Nurse until three weeks ago. She revealed the facility initially entered outbreak status on 08/24/21. She indicated that positive cases were identified 09/03/21, /9/24/21, /10/01/21,10/08/21, and 10/14/21. She revealed facility wide testing was conducted and she did not know why Agency Staff #1, #2, or #3 had not been tested every 3 to	F 886	Systemic Change: All staff were re-educated the Infection Control Preventionist/Staff Development Coordinator on or before 11.23.2021 regarding the facility□s testing guidelines. The IPCO/SDC/designee will maintain a roster of agency employees and validate the appropriate testing. Monitoring: The Director of Nursing/designee will conduct random weekly audits of the agency roster to validate appropriate testing x 12 weeks. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the DON monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	

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F 886	Continued From page 63 7 days during the facility outbreak status. She indicated staff should be tested weekly per the protocol. Interview with the Administrator on 10/21/21 at 3:57 PM revealed she did not know why the agency staff had not been tested for COVID-19 weekly per the protocol.	F 886		