STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345213	A. BUILDING ______ B. WING ______	C 02/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE LILLINGTON	1995 EAST CORNELIUS HARNETT BOULEVARD LILLINGTON, NC 27546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and compliant investigation survey was conducted on 01/30/2022 through 02/04/2022. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # KX2L11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 01/30/2022 through 02/04/2022. 2 of 10 complaint allegations were substantiated resulting in deficiencies. Substandard Quality of Care was identified at: CFR 483.24 at tag F680 at a scope and severity (F) An extended survey was also conducted.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550		3/15/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/28/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 550	Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews the facility failed to answer the call light for 1 of 1 resident (Resident #110). The resident expressed she felt ignored, disrespected and powerless. The findings included: Resident #110 was admitted on 12/20/19 with diagnoses that included muscle weakness, diabetes mellitus and hypertension. Review of Resident #110's care plan dated	F 550	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of the requirement under state and federal law, and to demonstrate the good faith attempts by the provider to provide/improve the quality of life of each	

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F 550	Continued From page 2 1/14/22 revealed Resident #110 required staff assistance for all activities of daily living. Resident #110's most recent Minimum Data Set (MDS) assessment dated 1/17/22, a quarterly assessment revealed she was cognitively intact with no behaviors. She required extensive assistance with bed mobility, locomotion, dressing, and personal hygiene. She was assessed as dependent for transfers and toilet use. She was assessed as always incontinent of bowel and bladder. On 1/30/22 at 3:10 PM, Resident #110 was interviewed. During the interview with the resident, she reported she was wet and needed to be changed but no one had responded to her call light. She reported she felt ignored and disrespected. Resident #110 indicated she felt staff ignoring her requests for assistance made her feel powerless. She reported her call light had been on since after receiving her lunch tray but was unaware of the time. Resident #110 stated her call light was frequently not answered but was not able to give additional specifics. A continuous observation was conducted on 1/30/22 from 3:10 PM until 3:44 PM and no staff came to Resident #110's room. Her call light was on in the hallway. From the hallway staff could be observed sitting at the nurse's station. Nurse #4 was interviewed on 1/30/22 at 3:45 PM. He was sitting at the nurse's station with Resident #110's room in his line of vision. He stated he did not hear the call light and was unaware Resident #110 had pressed her call light. Nurse #4 was observed entering Resident #110's	F 550	resident. F550 IMMEDIATE ACTION: Nurse aide #3 entered resident room and provided care to resident #110 on 1/30/2022 at 3.50pm. Resident #110 needs were met. Nurse #4 turned the tone “back on” on the call bell monitoring system located at the nurse’s station #2 (the station with resident #110 room) on 1/30/2022 when realized the sound was turned off on the system and could hear the call bell afterward. IDENTIFICATION OF OTHERS: 100% inspection of call bell monitoring system in the facility were completed by the Director of Nursing on February 22, 2022, to identify any other system with a low/no volume. It was noted that the sound of nurse’s station #1 and nurses’ station #2 were turned on and audible on February 22, 2022. Findings of this inspection is documented on a call system monitoring audit tool located in the facility compliance binder. 100% audit of current resident clinical documentation, and grievance log for the last 2 weeks was completed by Director of Nursing on February 22, 2022, to identify any issues with call bells not being answered in a timely manner. No other issues identified during this audit. Findings of this audit is documented on a “a call bell audit tool” located in the facility compliance binder.	

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F 550	Continued From page 3 room at 3:47 PM, upon his return to the nursing station he stated Resident #110 denied any assistance was needed. An interview was conducted with Resident #110 with Nurse #4 on 1/30/22 at 3:50 PM. She stated Nurse #4 misunderstood her and she needed to be changed. Nurse Aide #3 was observed entering Resident #110's room at 3:55 PM. During an interview with Resident #110 on 1/31/22 at 9:00 AM she stated she was changed when NA #3 entered the room as observed. On 2/4/22 at 2:55 PM, the Director of Nursing stated her expectation was for the call lights to be answered as soon as possible. She stated if staff were sitting at the nurse's station, they should have responded to Resident #110's call light.	F 550	SYSTEMIC CHANGES: On February 22, 2022, the contracted vendor who deals with the call bell system was contacted by the Corporate Plant operation consultant. The licensed vendor came on site on February 22, 2022, and disabled the "tone off button" on all the call bell monitoring systems. This adjustment will assure the call bell tone remains on at all times. Effective March 8, 2022, the facility will treat each resident with respect and dignity through answering call bells in a timely manner, and the call bell monitoring system will be audible at all times per manufacturer's specification. 100% education of all current employees to include full time, part time, and as needed employees completed by the Director of Nursing, Assistant Director of Nursing, MDS coordinators (#1, #2) and/or Unit Coordinators (#1, #2). The emphasis of this education includes, but not limited to the importance of answering call bells in a timely manner, anticipating each residents' needs, ensuring the call bell monitoring system is audible, and ensure each resident is treated with dignity and respect. This education will be completed by March 15, 2022. Any employee not educated by March 15, 2022, will not be allowed to work until educated. This education has been added on new hire orientation for all new hires effective March 8, 2022. MONITORING PROCESS:	

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F 550	Continued From page 4	F 550	Effective March 8, 2022, the Director of Nursing, Assistant Director of Nursing, MDS coordinators (#1, #2) and/or Unit Coordinators (#1, #2) will complete call bell monitoring to ensure employees are answering call bells in a timely manner, anticipating each residents' needs, and ensuring that each resident is treated with dignity and respect. This monitoring process will be accomplished by interviewing five residents daily for two weeks, weekly for two more weeks, then monthly for three months, or until the pattern of compliance is established. Effective March 8, 2022, the Director of Nursing, Assistant Director of Nursing, MDS coordinators (#1, #2) and/or Unit Coordinators (#1, #2) will complete call bell monitoring to ensure the call bell monitoring system is audible. This monitoring process will be accomplished by inspecting the call bell monitoring station at each nurse's station to ensure the volume is audible daily for two weeks, weekly for two more weeks, then monthly for three months, or until the pattern of compliance is established. Effective March 15, 2022, the Director of Nursing and/or assistant Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee (QAPI), for recommendations and/or modifications, monthly for three months, or until the pattern of compliance is achieved established.	

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F 550	Continued From page 5	F 550	RESPONSIBLE PARTY: Effective March 15, 2022, the Executive Director and the Director of Nursing will be ultimately responsible for the implementation of this plan of correction and ensure that the facility attain and maintain substantial compliance.	
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to place a resident's water cup in reach to allow a resident to drink fluids as desired for one of one resident reviewed for accommodation of needs (Resident #12). The findings included: Resident #112 was admitted to the facility on 4/29/21 with diagnoses that included muscle weakness, unsteadiness of feet and aphasia (a language disorder that affects a person's ability to communicate). The quarterly Minimum Data Set (MDS) assessment dated 11/4/21 indicated Resident 112's cognition was significantly impaired. She had no behaviors and no rejection of care. She required extensive assistance with bed mobility,	F 558	F558 IMMEDIATE ACTION: Unit coordinator #1 moved the water pitcher and placed it within resident #112 reach on 2/3/2022. IDENTIFICATION OF OTHERS: 100% inspection of current residents with water Pitchers/cups in the facility was completed by the Director of Nursing, Unit Manager #1, and/or Unit Manager #2 on February 23, 2022, to identify any other Pitchers/cups in the facility not within residents' reach. It was noted that all other residents with water pitcher/cup were within their reach on February 23, 2022. Findings of this inspection is documented on a "water pitcher audit tool" located in the facility compliance binder.	3/15/22

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F 558

Continued From page 6
transfers, locomotion on/off unit, dressing, eating, toileting, personal hygiene, and bathing.

An observation was conducted on 1/30/22 at 3:28 PM. Resident #112 was lying on her back in her bed and her water cup was observed to be in the windowsill out of her reach. Resident #112 was unable to be interviewed.

An observation was conducted of Resident #112 on 2/1/22 at 10:10 AM. She was observed lying on her bed and her water cup was observed on her tray table approximately five feet out of her reach.

During an observation on 2/2/22 at 8:34 AM Resident #112 was observed eating breakfast. She was observed feeding herself and drinking liquids from her tray. Her water cup was observed in the windowsill out of her reach.

An interview with conducted with Nursing Assistant (NA) #3 on 2/3/22 at 10:53 AM. She indicated she was familiar with Resident #112. She stated Resident #112's water cup should be in her reach so she would be able to get water as desired. NA #3 stated Resident #112 was able to drink unassisted.

An interview was conducted with the Unit Manager on 2/3/22 at 11:00 AM regarding Resident #112's water cup not being placed within her reach. She stated resident water pitchers should always be in reach.

During an interview with the Director of Nursing on 2/4/22 she stated residents should always be able to access their water cups . She further stated water cups should not be placed out of a

F 558

100% audit of current resident clinical documentation, and grievance log for the last 2 weeks was completed by Director of Nursing on February 23, 2022, to identify any documented concerns related to routinely used items not being within the resident's reach. No other issues identified during this audit. Findings of this audit is documented on a "an accommodation of needs audit tool" located in the facility compliance binder.

SYSTEMIC CHANGES:
Effective March 8, 2022, the facility will ensure each resident receive services in the facility with reasonable accommodation of resident needs and preferences to include keeping the water pitchers/cups within their reach as appropriate.

100% education of all current employees to include full time, part time, and as needed employees completed by the Director of Nursing, Assistant Director of Nursing, MDS coordinators (#1, #2) and/or Unit Coordinators (#1, #2). The emphasis of this education includes, but not limited to, the importance of ensuring each resident receive services in the facility with reasonable accommodation of resident needs and preferences to include keeping the water pitchers/cups within their reach as appropriate. This education will be completed by March 15, 2022. Any employee not educated by March 15, 2022, will not be allowed to work until educated. This education will be added to

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F 558	Continued From page 7 resident's reach.	F 558	new hire orientation for all new hires effective March 8, 2022. MONITORING PROCESS: Effective March 8, 2022, the Director of Nursing, Assistant Director of Nursing, MDS coordinators (#1, #2) and/or Unit Coordinators (#1, #2) will complete accommodation of needs monitoring process. This monitoring process will be accomplished by observing residents to ensure employees are providing services in the facility with reasonable accommodation of resident needs and preferences to include keeping the water pitchers/cups within their reach as appropriate. The monitoring process will include five residents daily for two weeks, weekly for two more weeks, then monthly for three months, or until the pattern of compliance is established. Any negative findings will be addressed by the Director of nursing promptly. This monitoring process will be documented on an “accommodation of needs monitoring tool” located in the facility compliance binder. Effective March 15, 2022, the Director of Nursing and/or assistant Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee (QAPI), for recommendations and/or modifications, monthly for three months, or until the pattern of compliance is achieved. RESPONSIBLE PARTY: Effective March 15, 2022, the Executive	

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F 558	Continued From page 8	F 558	Director and the Director of Nursing will be ultimately responsible for the implementation of this plan of correction and ensure that the facility attains and maintains substantial compliance.	
F 570 SS=C	Surety Bond-Security of Personal Funds CFR(s): 483.10(f)(10)(vi) §483.10(f)(10)(vi) Assurance of financial security. The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to have a surety bond sum that was greater than the balance in the residents' fund account. This deficient practice had the potential to affect 118 of 118 residents in the nursing home. Findings included: During an interview with the Business Office Manager (BOM) on 2/4/22 at 1:09 PM she stated the amount in the residents' fund account was $167, 234.70. She stated the amount of the surety bond was $150,000. The BOM stated she was unaware the surety bond needed to be equal or greater than the amount in the residents' funds account. She further stated she believed there had been some discussion by the Administrator of increasing the surety bond but had not heard anything about the amount or details of the increase. The Administrator provided an email dated 2/1/22	F 570	F570 IMMEDIATE ACTION: No resident was named in this alleged noncompliance. Business Office Manager notified the Eastern Regional Business Office Consultant of the needed Surety Bond increase on February 03, 2022 On February 14, 2022, the facility received a copy of the surety bond that assure the security of up to $190,000 of all personal funds of residents deposited with the facility. The bond was signed on February 11,2022 with an effective date of November 01, 2021. IDENTIFICATION OF OTHERS: 100% audit of residents' personal funds deposited with the facility was completed by the business office manager on February 23, 2022, to identify if the total amount in the resident's fund account exceeds the surety bond amount	3/15/22

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F 570	Continued From page 9 which revealed the facility was working towards increasing the bond amount. An interview with the Administrator was conducted on 2/4/22 at 4:15 PM which he stated the facility had requested an increase in the surety bond amount but it was not in place yet.	F 570	($190,000). It was noted that the amount in resident fund account did not exceed the surety bond that assure the security of all personal funds of residents deposited with the facility. SYSTEMIC CHANGES: Effective February 23, 2022, Business office manager will notify the facility Administrator, and the Regional Business Office Consultant if/when the resident trust account gets within $5,000 of the surety Bond and secure an increase of the Surety Bond (when applicable) to an amount sufficient to assure the security of all personal funds of residents deposited with the facility. Regional Business Office Consultant provided an education to the facility Business office manager and the Administrator on February 24, 2022. The emphasis of this education includes the importance of ensuring that surety bond assures the security of all personal funds of residents deposited with the facility and the importance of communicating with the regional business office manager when the resident trust amount is within $5000 of the surety bond. This education is added on new hire orientation for any new Business office manager and new Administrator effective February 24, 2022. MONITORING PROCESS: Effective February 23, 2022, Business office Manager will complete monitoring of resident trust account balance to ensure the trust account balance is not within	

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F 570	Continued From page 10	F 570	$5000 of the surety bond. This monitoring process will be done daily (Monday through Friday) for two weeks, weekly for two weeks, then monthly for 3 months or until a pattern of compliance is established. Effective March 15, 2022, the Business office manager will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee (QAPI), for recommendations and/or modifications, monthly for three months, or until the pattern of compliance is achieved. RESPONSIBLE PARTY: Effective March 15, 2022, the Executive Director and the Director of Nursing will be ultimately responsible for the implementation of this plan of correction and ensure that the facility attains and maintains substantial compliance.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain	F 656		3/15/22

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F 656	Continued From page 11 or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and record review, the facility failed to develop a comprehensive care plan for 2 of 2 residents reviewed for activities (Resident #371 and Resident #67). The findings included: 1. Resident #371 was admitted to the facility on	F 656	F656 IMMEDIATE ACTION: MDS coordinator #1 developed a comprehensive person-centered activity care plan for resident #67 and resident #371 on 2/04/2022 that includes measurable objectives, personal preferences, and activities of choice.	

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F 656	Continued From page 12 1/20/22 with diagnoses that included hypertension and aphasia. The admission Minimum Data Set (MDS) assessment dated 1/27/22 indicated Resident #371's cognition was moderately impaired. He had no behaviors and no rejection of care. A review of Resident #371's comprehensive care plan dated 1/30/22 did not include a care plan for activities. During an interview with the Activities Assistant on 2/2/22 at 12:09 PM she stated she began her position as the Activities Assistant on 1/11/22. She reported she was not doing any assessments or participating in any care planning meetings. An interview was conducted with the Administrator on 2/2/22 at 12:15 PM he stated the facility had an interim Activities Director who worked in the Therapy Department. An interview was conducted with the interim Activities Director on 2/2/22 at 12:35 PM who stated she is an Occupational Therapist who was approached by the Assistant Administrator regarding being the interim Activities Director. She stated she continued to have her same therapy caseload and did not consider herself the "director". The interim Activities Director stated the Activities Assistant was leading all the activities in the building. She further stated she was not participating in care plan meetings or conducting any assessments. During an interview with MDS Nurse #2 on 2/2/22 at 12:52 PM she stated she was conducting the	F 656	IDENTIFICATION OF OTHERS: 100% audit of current residents' care plans completed by MDS coordinator #1 and/or MDS coordinator #2 on February 28, 2022, to identify any other resident without an activity care plan. No other residents identified without activity care plan during this audit. Findings of this audit is documented on a "care plan audit tool" located in the facility compliance binder. SYSTEMIC CHANGES: Effective March 8, 2022, the facility will develop and implement a comprehensive individualized care plan for each resident including a care plan for activities. The development of a care plan for Activities will be accomplished by implementing the following systemic changes. Effective March 8,2022, the facility Executive Director will ensure the activity program is always directed by a qualified professional who will be responsible to oversee the activity program, develop an activity care plan for each resident, and revise the activity care plan as appropriate based on resident wishes and preferences. Effective March 8,2022, MDS coordinator #1 and/or MDS coordinator #2 will be responsible for developing an activity care plan for each resident and revise the activity care plan as appropriate based on resident wishes and preferences in the absence of the Activity Director.	

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F 656 Continued From page 13
interviews for the Activities portion of the Minimum Data Set assessments. She stated she had relayed the information regarding the residents' likes and dislikes to the Activities Assistant.

An interview was conducted with the Activities Assistant on 2/4/22 at 11:54 AM who stated Resident #371 had participated in coffee time, bingo, and bowling. She stated he was already in the room when these activities began, and he seemed to like them. The Activities Assistant stated she had not done any individual sessions with Resident #371.

An interview was conducted with the Administrator on 2/4/22 at 4:15 PM who stated the facility was in the process of hiring an Activities Director.

Resident #371 was unable to be interviewed.

2. Resident #67 was admitted to the facility on 2/6/20 with diagnoses that included diabetes mellitus and chronic obstructive pulmonary disease.

Her quarterly MDS assessment dated 12/18/21 revealed she was cognitively intact. She had no behaviors or rejection of care.

A review of Resident #67's comprehensive care plan dated 12/7/21 read in part, "unable to participate in activities due to bed rest". The care plan goal was to enjoy individual activities. Interventions included: schedule individual activities in room daily and create an activity plan around resident's preferences.

F 656

On February 28, 2022, Regional Director of operation re-educated the facility Executive Director on the regulatory requirement related to Activity program. This education included the importance of ensuring the activity program is always led by a qualified professional who will be responsible for development and revision of care plans. This education is will also be added to new hire orientation for any new Executive Director at the facility effective March 8, 2022.

Education will be provided to the interim Activity director, MDS coordinator #1 and/or MDS coordinator #2 by the facility Executive Director. The emphasis of this education includes, but not limited to ensuring that the activity program is always directed by a qualified professional, developing an activity care plan for each resident, and revising the activity care plan as appropriate based on resident wishes and preferences. This education will be completed by March 15, 2022, any employee not educated by March 15, 2022, will not be allowed to work until educated. This education is added to new hire orientation for all new hires effective March 8, 2022.

MONITORING PROCESS:
Effective March 8, 2022, MDS coordinators #1, and/or MDS Coordinator #2 will complete a monitoring process to ensure each resident has an activity care plan developed and revised and ensuring that each activity care plan is person-centered with measurable goals.

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F 656	Continued From page 14 During an interview with the Activities Assistant on 2/2/22 at 12:09 PM she stated she began her position as the Activities Assistant on 1/11/22. She reported she was not doing any assessments or participating in any care planning meetings. She reported she did group activities daily and visited other residents as she had time. The Activities Assistant stated she did not have a schedule for individual sessions. She reported she had met with Resident #67 and the resident let her do her nails. The Activities Assistant stated she believed Resident #67 liked to read and her family would bring her books. She further stated she was unaware of Resident #67's other interests. An interview was conducted with MDS Nurse #2 on 2/2/22 at 12:52 PM who stated Resident #67's comprehensive care plan should be resident-specific and include Resident #67's activity preferences. An observation was conducted on 2/3/22 at 3:23 PM. The Activities Assistant was observed with Resident #67 in her room sitting having a conversation. An interview was conducted with Resident #67 on 2/4/22 at 11:35 AM. She reported the Activities Assistant has come to her room weekly for approximately three weeks. Resident #67 stated prior to the Activities Assistant coming to her room, she had not seen anyone from the Activities Department. Resident #67 stated she enjoyed reading and crochet. During an interview with the Administrator on 2/4/22 at 4:15 PM who stated the facility was in the process of hiring an Activities Director.	F 656	This monitoring process will be accomplished by reviewing care plan for all completed Omnibus Budget Reconciliation Act (OBRA) MDS assessment to ensure Activity Care plan is included. This will be done daily (Monday to Friday) for two weeks, weekly for two more weeks, then monthly for three months, or until the pattern of compliance is established. Effective March 15, 2022, Interim Activity Director, Activity Director, MDS coordinators #1, and/or MDS Coordinator #2 will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee (QAPI), for recommendations and/or modifications, monthly for three months, or until the pattern of compliance is achieved. RESPONSIBLE PARTY: Effective March 15, 2022, the Executive Director and the Director of Nursing will be ultimately responsible for the implementation of this plan of correction and ensure that the facility attains and maintains substantial compliance.	

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F 679	Continued From page 15	F 679		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observations, family member and staff interviews, and record review, the facility failed to provide an ongoing resident centered activities program based on identified resident's individual interests for 1 of 1 resident reviewed for activities (Resident #67). The findings included: Resident #67 was admitted to the facility on 2/6/20 with diagnoses that included diabetes mellitus and chronic obstructive pulmonary disease. Her quarterly MDS assessment dated 12/18/21 revealed she was cognitively intact. She had no behaviors or rejection of care. Resident #67's annual MDS assessment dated 8/9/21 revealed her activity preferences were noted to be very important for listening to music, having reading materials, and keeping up with the news.	F 679	F679 IMMEDIATE ACTION: MDS coordinator #1 developed/revised a comprehensive person-centered activity care plan for resident #67 to includes measurable objectives, personal preferences, and activities of choice. IDENTIFICATION OF OTHERS: 100% interview for all current residents in the facility completed by MDS coordinator #1, MDS coordinator #2, and/or Activity assistant on February 28, 2022, to identify preferences of each resident to ensure an ongoing activity program support each resident in their choice of activities to include one on one activity in residents' room. Findings of this audit was used to revise each resident activity program and/or activity care plan completed on February 28, 2022. Findings of this audit is documented on a "care plan audit tool" located in the facility compliance binder.	3/15/22

F 679

Continued From page 16

A review of Resident #67's comprehensive care plan dated 12/7/21 read in part, "unable to participate in activities due to bed rest". The care plan goal was "enjoy individual activities." Interventions included schedule individual activities in room daily and create an activity plan around resident's preferences.

During an interview with the Activities Assistant on 2/2/22 at 12:09 PM she reported she began as Activities Assistant on 1/11/22. She reported she did group activities daily and visited other residents as she had time. The Activities Assistant stated she had stopped by Resident #67's room and she felt like Resident #67 did not want to be bothered. She reported she had met with Resident #67 on one occasion and the resident let her do her nails. She further stated she was unaware of Resident #67's activity preferences.

An observation was conducted on 2/3/22 at 3:23 PM. The Activities Assistant was observed with Resident #67 in her room sitting having a conversation.

An interview was conducted with Resident #67 on 2/4/22 at 11:35 AM. She stated the Activities Assistant has been coming by her room for approximately three weeks. She stated until the past three weeks she was not receiving individual activities in her room. Resident #67 stated she could not remember receiving individual activities in her room prior to the Activities Assistant's visits.

An interview was conducted with the Administrator on 2/4/22 at 4:15 PM who stated the Activities Assistant was new in her position

F 679

100% interview for all current residents' family members for those residents who are rarely/never understood completed by MDS coordinator #1, MDS coordinator #2, and/or Activity assistant on February 28, 2022, to identify preferences of each resident to ensure an ongoing activity program support each resident in their choice of activities to include one on one activity in residents' room.
On February 28,2022, employees familiar with the resident were interviewed when a family member or significant other was not available for interview for those residents who are rarely/never understood to identify preferences of each resident to ensure an ongoing activity program support each resident in their choice of activities to include one on one activity in residents' room.

SYSTEMIC CHANGES:
Effective March 8, 2022, the facility provides based on comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent. This will be accomplished by implementing the following systemic modifications:
Effective March 8,2022, the facility Executive Director will ensure the activity program is directed by the qualified professional at all times who will be responsible to oversee the activity program, develop activity care plan for

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F 679	Continued From page 17 and the interim Activities Director worked as an Occupational Therapist in the building.	F 679	each resident, and provide/oversee the activity program based on resident wishes and preferences as indicated on their assessment. Effective March 8, 2022, the activity staff to include activity director, interim activity director, and activity aide will have access to each resident’s activity assessment and care plan maintained in each resident’s electronic medical records. Activity staff will provide activity program based on each resident’s assessment and care plan. Effective March 8,2022, MDS coordinator #1 and/or MDS coordinator #2 will be responsible to develop activity care plan for each resident and revise the activity care plan as appropriate based on resident wishes and preferences in the absence of the Activity Director. On February 28, 2022, Regional Director of operation re-educated the facility Executive Director on the regulatory requirement related to Activity program. This education included the importance of ensuring the activity program is led by qualified personnel at all times who will be responsible for development and revision of care plan. This education is will also be added to new hire orientation for any new Executive Director at the facility effective March 8, 2022. An education will be provided to the interim Activity director, MDS coordinator #1 and/or MDS coordinator #2 by the facility Executive Director. The emphasis of this education includes, but not limited	

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F 679	Continued From page 18	F 679	to ensure that the activity program is directed by the qualified professional at all times, develop activity care plan for each resident, and revise the activity care plan as appropriate based on resident wishes and preferences. This education will be completed by March 15, 2022, any employee not educated by March 15, 2022, will not be allowed to work until educated. This education is added on new hire orientation for all new hires effective March 8, 2022. MONITORING PROCESS: Effective March 8, 2022, MDS coordinators #1, and/or MDS Coordinator #2 will complete interview randomly selected five residents to ensure they receive an ongoing resident centered activities program based their individual interests. This will be done daily (Monday to Friday) for two weeks, weekly for two more weeks, then monthly for three months, or until the pattern of compliance is established. Effective March 15, 2022, Interim Activity Director, Activity Director, MDS coordinators #1, and/or MDS Coordinator #2 will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee (QAPI), for recommendations and/or modifications, monthly for three months, or until the pattern of compliance is achieved. RESPONSIBLE PARTY: Effective March 15, 2022, the Executive	

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F 679	Continued From page 19	F 679	Director and the Director of Nursing will be ultimately responsible for the implementation of this plan of correction and ensure that the facility attains and maintains substantial compliance.	
F 680 SS=F	Qualifications of Activity Professional CFR(s): 483.24(c)(2)(i)(ii)(A)-(D) §483.24(c)(2) The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who- (i) Is licensed or registered, if applicable, by the State in which practicing; and (ii) Is: (A) Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or (B) Has 2 years of experience in a social or recreational program within the last 5 years, one of which was full-time in a therapeutic activities program; or (C) Is a qualified occupational therapist or occupational therapy assistant; or (D) Has completed a training course approved by the State. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to have an Activities Director in place who was responsible for directing the development, implementation, supervision, and ongoing evaluation of the activities program. This deficient practice had the potential to affect 118 of the 118 facility residents. The findings included:	F 680	F680 IMMEDIATE ACTION: On February 28, 2022, the facility Administrator appointed the former activity assistant who has had more than two years' experience in a recreational program within the last 5 years, one of which was full-time in a therapeutic	3/15/22

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During an interview with the Activities Assistant on 2/2/22 at 12:09 PM she reported she started her position on 1/11/22. She stated when she started this position there was no Activities Director. She reported no knowledge of an Activities Director currently. The Activities Assistant stated when she had questions, she asked another employee who had worked in activities previously or the Assistant Administrator. She reported she was not doing any assessments or participating in any care planning meetings.

An interview was conducted with the Administrator on 2/2/22 at 12:20 PM and he stated an Occupational Therapist had agreed to serve as the interim Activities Director as of 1/6/22.

Review of an undated job description for the Activity Director position read in part:
Essential functions and responsibilities:
· Completes assessments, MDS, care plans and gathers information to design activities that are multi-faceted, meets patients'
functional levels and reflects needs and interests of each patient.
· Through activities, provides stimulation or solace, promotes physical, cognitive, and/or emotional health.
· Provides patients who are confined or chose to remain in their rooms with in-room activities in keeping with life-long interest and
in-room projects they can work on independently.

During an interview with the interim Activities Director on 2/2/22 at 12:35 PM she stated she was asked by the Assistant Administrator to serve

F 680

activities program in our facility. The new interim activity director will be responsible to oversee the activity program effective March 08,2022.

On February 28, 2022, the facility Administrator reposted the activity director position on on-line recruitment platforms and will continue to review applicants for potential candidates.

IDENTIFICATION OF OTHERS:
100% audits of all regulatory required positions completed on February 28, 2022, by the facility administrator to ensure all required positions are filled with the qualified personnel. Findings of this audit is documented on a “regulatory required position audit tool” located in the facility compliance binder.

SYSTEMIC CHANGES:
Effective March 8,2022, the facility administrator will ensure the activity program is always directed by a qualified professional who will be responsible to oversee the activity program, develop activity care plan for each resident, and provide/oversee the activity program based on resident wishes and preferences as indicated on their assessment.

Effective March 8, 2022, the activity staff to include activity director, interim activity director, and activity aide will have access to each resident’s activity assessment and care plan maintained in each resident’s electronic medical records. Activity staff

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F 680	Continued From page 21 as the interim Activities Director 1/5/22 after the previous Activities Director was no longer employed with the facility. She reported the Activities Assistant does all the group activities. The interim Activities Director stated she was aware the Activities Assistant was conducting activities because she had observed activities in passing. She reported she still worked with her full therapy caseload. The interim Activities Director stated she would not consider herself the "director" but oversaw to ensure the Activities Assistant was conducting activities. She reported she did not participate in care plan meetings or conduct any assessment related to activities. The interim Activities Director stated she had not provided any supervision to the Activities Assistant regarding the activity needs of the residents. She verified that as the Interim Activities Director she was not responsible for directing the development, implementation, supervision, and ongoing evaluation of the activities program. An interview was conducted with the Director of Rehabilitation on 2/2/22 at 12:40 PM who stated his department had never been responsible for the activities program previously. He indicated the interim Activities Director had a full case load and there were no changes when she was titled the "Interim Activities Director". A second interview was conducted with the Activities Assistant on 2/2/22 at 3:40 PM. The Activities Assistant stated she was doing some notes and keeping them in a binder. She stated she kept the binder in the Activities closet because she did not know what to do with them. The Activities Assistant stated she did group activities daily and visited other residents as she	F 680	will provide activity program based on each resident's assessment and care plan. On February 28, 2022, Regional Director of operation re-educated the facility Administrator on the regulatory requirement related to Activity program. This education included the importance of ensuring the activity program is always led by a qualified professional who will be responsible for development and revision of care plan. This education is will also be added to new hire orientation for any new administrator at the facility effective March 8, 2022. Education will be provided to the interim Activity director, MDS coordinator #1 and/or MDS coordinator #2 by the facility Administrator. The emphasis of this education includes, but not limited to ensuring that the activity program is always directed by a qualified professional, developing an activity care plan for each resident, and revising the activity care plan as appropriate based on resident wishes and preferences. This education will be completed by March 15, 2022, any employee not educated by March 15, 2022, will not be allowed to work until educated. This education is added to new hire orientation for any new Activity director, MDS coordinator #1 and/or MDS coordinator #2 effective March 8, 2022. MONITORING PROCESS: Effective March 8, 2022, the Facility	

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F 680	Continued From page 22 had time. She stated she followed the January schedule during January. The Activities Assistant stated there had not been a February schedule developed. A follow up interview was conducted with the interim Activities Director on 2/2/22 at 4:06 PM. The interim Activities Director revealed she had not been consulted about the schedule and/or plan for activities for February. She further revealed she was not responsible for planning and/or scheduling activities. An interview was conducted with the Assistant Administrator on 2/3/22 at 2:30 PM. The Assistant Administrator stated the former Activities Director had been terminated from the facility. She further stated the interim Activities Director was unaware a calendar for activities needed to be developed so one had not been done. She reported she would advise the interim Activities Director of the need for a schedule. The Assistant Administrator reviewed the job description of the Activity Director position and stated the interim Activities Director was not performing the essential functions and responsibilities as listed. An interview was conducted with the Administrator on 2/4/22 at 4:15 PM who stated the facility was currently recruiting for an Activities Director.	F 680	Administrator will review open positions to ensure any regulatory required positions are filled with a qualified person to include an activity director position. This will be done daily (Monday to Friday) for two weeks, weekly for two more weeks, then monthly for three months, or until the pattern of compliance is established. Effective March 15, 2022, facility Administrator will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee (QAPI), for recommendations and/or modifications, monthly for three months, or until the pattern of compliance is achieved. RESPONSIBLE PARTY: Effective March 15, 2022, the facility administrator will be ultimately responsible for the implementation of this plan of correction and ensure that the facility attains and maintains substantial compliance.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive	F 684		3/15/22

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F 684

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assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review, staff interviews and physician interview, the facility failed to recheck a low blood pressure of 72/45 complete and document an admission assessment and vital sign data for 1 of 1 reviewed for quality of care (Resident #71) and failed to assess a resident after a fall before assisting back to bed for 1 of 1 resident reviewed for falls (Resident #27).

Findings included:

1. Resident #71 was admitted to the facility on 7/25/20 with a re-admission on 1/24/22.

Resident #71's diagnosis included atherosclerosis with gangrene to left lower leg and right lower leg and hypertension.

Record review revealed Resident #71 was readmitted to the facility on 1/24/22 status post bilateral below the knee amputations on 1/19/22. His admission blood pressure was 72/45. There was no documentation of a repeat blood pressure.

On 2/4/22 an interview was conducted with Nurse #1 at 12:35 PM. She stated she was the nurse on duty when Resident #71 returned from the hospital on 1/24/22. She stated Resident #71 had a blood pressure of 72/45 but was not symptomatic when he was admitted. Nurse #1

F 684

F684
IMMEDIATE ACTION:
Resident #71 is no longer in the facility. Nurse #2 documented in resident #27 medical records on February 4, 2022 “a late entry documentation” that included an assisted fall happened on January 31, 2022.

IDENTIFICATION OF OTHERS:
100% audit of all blood pressure obtained in the last 30 days completed on February 28, 2022, by Director of Nursing, Unit coordinator #1, and/or Unit manager #2 to identify any other blood pressure with systolic value (top number) less than 90 or diastolic value (bottom number) less than 60 documented in medical records without being rechecked. No other blood pressure results identified without appropriate follow through. Findings of this audit is documented on a “blood pressure audit tool” located in the facility compliance binder.

100% audit of all incident reports written in the last 30 days completed on February 28, 2022, by Director of Nursing, Unit coordinator #1, and/or Unit manager #2 to identify any other incidence of falls or assisted falls not documented in medical records. No other incidents/accidents

F 684

Continued From page 24

also stated she did not re-check his blood pressure during the remainder of her shift.

On 2/4/22 at 3:25 PM an interview was conducted with the unit manager, and she stated the Resident #71's assessment and vital signs should have been rechecked.

An interview was conducted with the Administrator on 2/4/22 at 4:20 PM. He stated Nurse #1 should have rechecked Resident #71's vital signs.

A telephone interview was conducted with Resident #71's physician on 2/4/22 at 4:05 PM and he stated he would have expected the nurse to recheck a blood pressure of 72/45 and call him for if there was no change.

A review of the medical record revealed no documentation of an admission assessment and the vital sign data for Resident #71 on 1/24/22.

On 2/4/22 an interview was conducted with Nurse #1 at 12:35 PM. She stated she was the nurse on duty when Resident #71 returned from the hospital on 1/24/22. She stated she did an assessment with vital signs on Resident #71 and wrote it on the 24-hour nurses report sheet. She stated she didn't put the assessment or his vital signs into the medical record.

A review was made of the 24-hour nurses report sheet for 1/24/22. Written data on the sheet included Resident #71's vital signs, blood glucose level, diagnosis, notation of a wound, and medications.

On 2/4/22 at 3:25 PM an interview was conducted

F 684

were identified that were not documented in the medical records. Findings of this audit is documented on an “Incident report audit tool” located in the facility compliance binder.

SYSTEMIC CHANGES:
Effective March 8, 2022, the Director of nursing set the parameter that will automatically require a recheck of any documented systolic blood pressure less than 90 and/or diastolic blood pressure less than 60 in the electronic health record software used by the facility. This change will ensure any documented low blood pressure is rechecked promptly.

Effective March 8, 2022, the Director of nursing set the parameter that will automatically transfer the details of incident report entered in “incident report module” to automatically transfer to the facility’s clinical documentation to ensure each incident is documented at the same time when an incident report is entered. Effective March 1, 2022, the facility’s Licensed nurses, Medication aides, and Certified nursing aides will document all resident assessments, vital signs, and/or incident/accidents to include assisted falls to each resident’s electronic medical records.

100% education of all current Licensed nurses, Medication aides, and Certified nursing aides to include full time, part time and as needed employees completed by the Director of Nursing, Assistant Director of Nursing, Unit coordinator #1 and/or Unit

F 684

Continued From page 25

with the unit manager, and she stated Resident #71's assessment and vital signs should have been placed in the medical record.

An interview was conducted with the Administrator on 2/4/22 at 4:20 PM. He stated the admission assessment and vital signs should have been documented in the resident's record.

2. Resident #27 was admitted to the facility on 3/3/2021. His diagnoses include difficulty walking and unsteadiness on feet.

The care plan dated 3/10/2021 revealed Resident #27 was at risk for falls and injury related to weakness and impaired mobility. Interventions included bed in low position, resident in the center of the bed, encouraging the use of the call light to request assistance, arranging furniture in his reach, and monitoring for changes in condition that may warrant increased supervision and assistance and notifying the physician.

The admission Minimum Data Set (MDS) assessment dated 3/12/2021 indicated Resident #27 was severely cognitively impaired with impairments to both lower extremities and indicated no history of falls. The 5-day MDS dated 1/25/22 revealed Resident #27 was severely cognitively impaired with impairments to both upper and lower extremities and had experienced two or more falls without injury.

On 1/31/2022 at 10:03 a.m., a continuous observation started when Resident #27 was observed with his head and upper body on the floor, his waist was over the edge of the bed and his feet and legs were on the bed when entering

F 684

coordinator #2. The emphasis of this education includes, but not limited to, the importance of ensuring all resident's assessments, vital signs, and/or incident/accidents to include assisted falls are documented on each resident electronic medical records; and ensure any systolic blood pressure less than 90 and/or diastolic blood pressure less than 60 is rechecked immediately following the electronic medical records prompt. This education will be completed by March 15, 2022. Any Licensed nurses, Medication aides, and Certified nursing aides not educated by March 15, 2022, will not be allowed to work until educated. This education is added to new hire orientation for all Licensed nurses, Medication aides, and Certified nursing aides effective March 8, 2022.

MONITORING PROCESS:
Effective March 8, 2022, Director of nursing, Assistant Director of Nursing, and/or Unit coordinator #1 and/or Unit coordinator #2, will monitor compliance by reviewing incident reports, vital signs, admissions, and readmissions in the daily clinical meeting (Monday-Friday), to ensure that all resident assessments, vital signs and incident/accidents are documented in medical records. Any issues identified during this monitoring process will be addressed promptly. This monitoring process will be completed daily Monday through Friday for two weeks, weekly for two more weeks, then monthly for three months or until the pattern of compliance is maintained. Findings of this

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F 684	Continued From page 26 his room. The bed was positioned low to the floor. Nurse #2 was called to Resident #27's room. Nurse #2 was observed entering Resident #27's room, assisting him to the floor and exiting his room. Nurse #2 was not observed re-entering Resident #27's room. At 10:08 a.m. Nurse Aide (NA) #1 and NA #2 were observed entering the room to assist Resident #27 back into the bed. On 1/31/2022 at 10:43 p.m. a review of the nursing documentation revealed no documentation of a fall for Resident #27 on 1/31/2022. On 2/4/2022 at 11:00 a.m. in an interview with Nurse #2 , she stated on 1/31/2022 Resident #27 was trying to get out of the bed, and she assisted him to the floor. She stated since she assisted him to the floor, she did not consider it a fall. Nurse #2 stated Resident #27's head was on the floor, and she did not witness how Resident #27 got into that position. Nurse #2 stated she assessed Resident #27 after NA #1 and NA #2 assisted him back to bed , and Resident #27 was without any complaints of injury or complication. Nurse #2 further stated she did not know what the procedures were after a fall. On 2/4/2022 at 11:30 a.m. in an interview with the Director of Nursing, she stated she was not aware of a fall with Resident #27 on 1/31/2022, and Resident #27's fall was not discussed at the morning meeting on 2/1/2022. She stated Resident #27 being on the floor was considered a fall, and Nurse #2 should have returned to Resident#27's room to assess Resident #27 before he was moved back to bed. On 2/4/2022 at 3:43 p.m., a review of Nurse #2's	F 684	monitoring process will be documented on “clinical documentation monitoring form” located in the facility compliance binder. Effective March 8, 2022, Director of nursing, Assistant Director of Nursing, and/or Unit coordinator #1 and/or Unit coordinator #2, will monitor compliance by reviewing blood pressures obtained in the prior 24 hours or from last clinical meeting to ensure any systolic blood pressure less than 90 and/or diastolic blood pressure less than 60 was rechecked immediately following the electronic medical records prompt. This monitoring process will be completed daily Monday through Friday for two weeks, weekly for two more weeks, then monthly for three months or until the pattern of compliance is maintained. Findings of this monitoring process will be documented on a “Vital signs monitoring form” located in the facility compliance binder. Effective March 15, 2022, the Director of Nursing and/or Assistant Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee (QAPI), for recommendations and/or modifications, monthly for three months, or until the pattern of compliance is achieved. RESPONSIBLE PARTY: Effective March 15, 2022, the Executive Director and the Director of Nursing will be responsible for the implementation of this plan of correction and ensure that the facility attains and maintains substantial	

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F 684	Continued From page 27 orientation folder revealed a document, "Fall Incident Reporting Process" was signed and dated by Nurse #2 on 10/26/2021.	F 684	compliance.	
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews with facility staff the facility failed to provide foot care for 1 of 1 resident (Resident #110) dependent on staff for activities of daily living (ADLs). The findings included: Resident #110 was admitted on 12/20/19 with diagnoses that included muscle weakness, diabetes mellitus and hypertension. Review of Resident #110's care plan dated 1/14/22 revealed Resident #110 required staff assistance for all activities of daily living. Resident #110's quarterly Minimum Data Set (MDS) assessment dated 1/17/22 revealed she	F 687	F687 IMMEDIATE ACTION: On February 2, 2022, Unit Coordinator #1 provided nail care to resident #110. Resident #110 refused cutting and filing her toenails stating that "she prefers for them to remain long" IDENTIFICATION OF OTHERS: 100% inspection of current residents' toenails was completed by Unit coordinator #1, and/or Unit manager #2 on February 23, 2022, to identify any other resident with a need for toenail care. No other issues were identified during this audit. Findings of this audit is documented on a "Foot care audit tool" located in the facility compliance binder.	3/15/22

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was cognitively intact with no behaviors. She required extensive assistance with bed mobility, locomotion, dressing, and personal hygiene.

An observation and interview on 1/31/22 at 10:09 AM revealed all Resident #110's toenails on both feet appeared very long, and the second toenail of her right foot was approximately 1/4 of an inch past her toes. The second toenail on her right foot was curled under towards her toe. Resident #110 stated she had asked for her toenails to be trimmed and her requests had been ignored. She was unable to give specific times or dates.

On 2/1/22 at 3:44 PM Resident #110 stated no one had trimmed her toenails although she had requested during her morning care from the Nurse Aide #4 on 2/1/22.

On 2/2/22 at 11:45 AM Nurse Aide #4 observed Resident #110's toenails and stated they needed to be trimmed. She stated nurses trim the toenails of residents with diabetes. NA #4 further stated she did not look at Resident #110's toenails when she provided care. She reported she was to provide foot care during bathing. She stated she was taught to notify the nurse if a resident with diabetes mellitus required foot care.

On 2/2/22 at 12:00 PM the Unit Manager observed Resident #110's toenails and stated they needed to be trimmed. The Unit Manager provided nail care to Resident #110. She further stated she expected the nurse aide assigned to let her know if a resident's nails needed to be trimmed.

An interview was conducted with the Director of Nursing (DON) on 2/4/22 at 1:34 PM who stated

F 687

SYSTEMIC CHANGES:
Effective March 8, 2022, the facility will ensure that residents receive proper treatment and care to maintain mobility and good foot health, to include providing foot care and treatment for all residents in accordance with professional standards of practice. This will be accomplished by instituting the following systemic changes.

On February 25, 2022, the Director of Nursing revised the skin assessment schedule utilized in facility. Resident’s weekly skin assessments schedule will show resident assessments, (to include the inspection of toenails), due between the days of Sunday and Thursday, every week. This will allow monitoring of completion of scheduled assessments by members of nursing administration Monday-Friday. Any identified toenails care needs discovered during skin assessments will be reported daily Monday thru Friday in the morning clinical meeting. The revised schedule will be utilized in the facility effective March 1, 2022.

Effective March 1, 2022, the facility’s Licensed nurses will complete head to toe skin assessment to include inspecting toenails of residents following the revised skin assessment schedule at least once weekly. Licensed nurses will ensure any resident identified of a need of toenail care will receive appropriate toenail care as appropriate.

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F 687	Continued From page 29 toenails should be trimmed as needed. She stated nurse aides should trim toenails unless the resident was diabetic. The DON stated nails could be trimmed by nurses for residents with diabetes.	F 687	Effective March 8, 2022, MDS coordinator #1 and/or MDS coordinator #2 will develop/revise individual resident's care plan for any resident who refuse nail care and/or prefer to have long toenails moving forward. 100% education of all current licensed nurses completed by the Director of Nursing, Assistant Director of Nursing, Unit coordinator #1 and/or Unit coordinator #2. The emphasis of this education includes, but not limited to, the importance of ensuring toenail care is identified and provided as appropriate. The education also emphasized the importance of completing weekly skin assessment per revised schedule and address any toenail needs identified. This education will be completed by March 15, 2022, any Licensed nurse not educated by March 15, 2022, will not be allowed to work until educated. This education is added to new hire orientation for all licensed nurses effective March 8, 2022. MONITORING PROCESS: Effective March 8, 2022, Director of nursing, Assistant Director of Nursing, and/or Unit coordinator #1 and/or Unit coordinator #2, will monitor compliance with resident's toenails care by reviewing the completion of the prior day weekly skin assessment on daily clinical meeting (Monday-Friday), to ensure any identified toenails care needs are addressed appropriately. Any issues identified during this monitoring process will be addressed promptly. This monitoring process will be	

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F 687	Continued From page 30	F 687	completed daily Monday through Friday for two weeks, weekly for two more weeks, then monthly for three months or until the pattern of compliance is maintained. Findings of this monitoring process will be documented on “skin assessment monitoring form” located in the facility compliance binder. Effective March 15, 2022, the Director of Nursing and/or Assistant Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee (QAPI), for recommendations and/or modifications, monthly for three months, or until the pattern of compliance is achieved. RESPONSIBLE PARTY: Effective March 15, 2022, the Executive Director and the Director of Nursing will be responsible for the implementation of this plan of correction and ensure that the facility attains and maintains substantial compliance.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 689		3/15/22

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Continued From page 31
by:
Based on record review, observation and staff interviews, the facility failed to assess 1 of 2 residents (Resident #109) reviewed for smoking and failed to remain with a resident while waiting for assistance after a fall for 1 of 4 residents (Resident #27) reviewed for falls.

Findings included:

The facility's, "Resident Smoking, Smoke Free Facility," policy dated February 2021 stated residents who smoke will be further assessed, using the Smoking Assessment, to determine whether or not supervision was required for smoking or if resident was safe to smoke at all. The policy further stated residents who have independent smoking privileges were permitted to keep cigarettes, pipes, tobacco, and other smoking articles in their possession, and only disposable safety lighters were permitted.

1. Resident # 109 was admitted to the facility on 10/27/2021. His diagnoses included osteomyelitis to left ankle and foot and abnormalities of gait and mobility.

The safe smoking evaluation dated 10/28/2021 indicated Resident #109 was a nonsmoker.

On 2/3/2022 at 2:52 p.m. in an interview with Nurse #3, she stated a smoking assessment was conducted before residents were able to smoke and stated smoking assessments were conducted on admission and quarterly. She stated Resident #109 was not listed as a smoker. She stated she had never observed Resident #109 smoking, believed he did go out to the designated smoking area, and he was allowed to

F 689

F689
IMMEDIATE ACTION:
Resident #109's smoking materials were removed from his possession on February 4, 2022, by Unit Coordinator #1. A safe smoking assessment was completed on February 4, 2022, for resident #109 by MDS Coordinator #2.
Resident #27 was assessed and assisted back into the bed by Nurse Aide #1 and Nurse Aide #2. Resident was noted to not have any injuries.

IDENTIFICATION OF OTHERS:
100% smoking audit of all residents in the facility was completed on March 1, 2022, to identify any potential smokers in the facility by the Director of Nursing, and unit coordinators (#1, #2). Findings of this audit is documented on the "Smoking Audit tool" and is in the facility compliance binder.

100% audit of all incident reports written in the last 30 days completed on February 28, 2022, by Director of Nursing, Unit coordinator #1, and/or Unit manager #2 to identify any other incident of fall or assisted fall not documented in medical records. No other incidents/accidents identified not documented in medical records. Findings of this audit is documented on a "Incident report audit tool" located in the facility compliance binder.

SYSTEMIC CHANGES:
All current residents will have an updated

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have cigarettes in his room. She stated Resident #109 was identified as a nonsmoker on the last smoking assessment dated 10/28/2021 and needed to be reassessed for smoking.

The admission Minimum Data Set (MDS) assessment dated 11/3/2021 indicated Resident #109 was cognitively intact, required supervision of one person for mobility and had no upper impairments.

Nursing documentation revealed on 11/24/2021 Resident# 109 was found smoking in his room. Resident #109 was educated that smoking was allowed outside the facility, and his cigarettes and lighter were placed at the nurse ' s station for safety concerns that shift.

On 12/20/2021, nursing documentation revealed Resident #109 had fresh burn holes in his pants from smoking, and the nursing staff continued to monitor Resident #109.

The care plan dated 12/21/2021 revealed a focus for smoking and safety. Interventions included to encourage to wear smoker apron, encourage resident to maintain all smoking materials at nursing station, and to encourage to smoke only during smoking hours posted and in designated areas.

On the facility's list of residents who smoke dated 1/30/2022. Resident #109 was not listed as a smoker.

On 1/30/2022 at 10:52 a.m., Resident #109 was observed on the COVID unit in the hallway in his wheelchair with a pack of cigarettes rolled into his right shirt sleeve. Resident #109 stated he went

F 689

smoking assessment to be completed by the Director of Nursing, Assistant Director of Nursing, Unit coordinators (#1, #2) on February 28, 2022, March 1,2022, and/or March 2, 2022. A new smoking list will be generated on the completion of the assessment by the Director of Nursing on March 2,2022
Effective March 8, 2022, all new residents will have a smoking assessment completed on admission, quarterly, and with any changes in their smoking status, by the licensed nurse on duty. This will be reviewed in the daily clinical meeting and be documented on the facility smoking list. Moving forward, all residents who smoke will be listed on the facility's "list of residents who smoke" and will be updated weekly by the Director of Nursing.

Effective February 28, 2022, no residents will be left unattended after being observed on the floor. Any staff member who observes a resident on the floor will ensure the resident is safe and then call for assistance by activating the call bell light. If no one comes immediately, staff will step outside of location and call for assistance.

100% education of all current staff to include full time, part time, and as needed employees will be completed by the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2). The emphasis of this education includes but not limited to, the importance of completing smoking assessment on admission, quarterly and with changes of

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UNIVERSAL HEALTH CARE LILLINGTON	1995 EAST CORNELIUS HARNETT BOULEVARD LILLINGTON, NC 27546

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over there to smoke, pointing down the hallway on the COVID unit toward the designated smoking area in the facility.

On 1/31/2022 at 10:46 a.m. Resident #109 was observed lying in the bed with a pack of cigarettes lying up against his pillow on top of his left upper arm. Resident #109 stated he used matches or a lighter and needed some matches. He stated he went out to smoke and usually smoked alone.

On 2/2/2022 at 11:56 a.m. in an interview with Medication Aide, she stated Resident #109 was a smoker and had not seen him go out to smoke since returning from the COVID unit.

On 2/2/2022 at 11:58 a.m. in an interview with Nurse Aide #1, she stated Resident #109 was an independent smoker.

On 2/4/2022 at 11:47 a.m. in an interview with the Director of Nursing, she stated smoking assessments were completed on admission and with a change in condition. She stated cigarettes should not be in the possession of residents determined as a nonsmoker. She stated Resident #109 was not a safe smoker and should have been reassessed for smoking.

2. Resident #27 was admitted to the facility on 3/3/2021. His diagnoses include difficulty walking and unsteadiness on feet.

The care plan dated 3/10/2021 revealed Resident #27 was at risk for falls and injury related to weakness and impaired mobility. Interventions included bed in low position, resident in the center of the bed, encouraging the use of the call light to request assistance, arranging furniture in his

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smoking status, supervised smokers and to report any changes in resident's ability to smoke safely. This education will be completed by March 15, 2022. Any staff members not educated by March 15, 2022, will not be allowed to work until educated. This education will be provided annually and will be added to new hire orientation for all new employees effective March 8, 2022.

100% education of all current staff to include full time, part time, and as needed employees will be completed by the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators. The emphasis of this education includes but not limited to, the incident and accident process and safety of our residents. This education will be completed by March 15, 2022. Any staff members not educated by March 15, 2022, will not be allowed to work until educated. This education will be provided annually and will be added to new hire orientation for all new staff members effective March 8, 2022.

MONITORING PROCESS:
Effective March 8, 2022, the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2) will review all new admissions for the last 24 hours or from last clinical meeting to ensure that a smoking assessment has been completed. Any negative findings will be corrected promptly. This monitoring process will be completed daily Monday through Friday for two weeks, weekly for two more weeks, then monthly for three

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reach, and monitoring for changes in condition that may warrant increased supervision and assistance and notifying the physician.

The admission Minimum Data Set (MDS) assessment dated 3/12/2021 indicated Resident #27 was severely cognitively impaired with impairments to both lower extremities and indicated no history of falls. The 5-day MDS dated 1/25/22 revealed Resident #27 was severely cognitively impaired with impairments to both upper and lower extremities and had experienced two or more falls without injury.

On 1/31/2022 at 10:03 a.m., a continuous observation started when Resident #27 was observed with his head and upper body on the floor, his waist was over the edge of the bed and his feet and legs were on the bed when entering his room. The bed was positioned low to the floor. Nurse # 2 was called to Resident #27's room. Nurse #2 was observed entering the room, assisting Resident #27 to the floor and exiting the room. Nurse #2 was observed returning to her medication cart and entering Resident #109's room while Resident #27 laid on the floor. Nurse #2 was not observed re-entering Resident #27's room. At 10:08 a.m. Nurse Aide (NA) #1 and NA #2 were observed entering the room to assist Resident #27 back into the bed.

On 1/31/2022 at 10:08 a.m. in an interview with NA #1, she stated Nurse #2 had informed her Resident #27 was on the floor.

On 2/4/2022 at 11:00 a.m. in an interview with Nurse #2, she stated on 1/31/2022 Resident #27 was trying to get out of the bed, and she assisted him to the floor. She stated she went to get some

months or until the pattern of compliance is maintained. Findings of this monitoring process will be documented on the “smoking assessment tool for new residents” located in the facility compliance binder.
Effective March 8, 2022, the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2) will review all incidents and accidents on daily clinical meeting to ensure that all residents were assisted promptly and not left unattended. This monitoring process will be completed daily Monday through Friday for two weeks, weekly for two more weeks, then monthly for three months or until the pattern of compliance is maintained. Findings of this monitoring process will be documented on the “Incidents and Accidents monitoring tool” located in the facility compliance binder.

Effective March 15, 2022, the Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee (QAPI), for recommendations and/or modifications, monthly for three months, or until the pattern of compliance is achieved.

RESPONSIBLE PARTY:
Effective March 15, 2022, the Executive Director and the Director of Nursing will be ultimately responsible for the implementation of this plan of correction and ensure that the facility attains and maintains substantial compliance.

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F 689	Continued From page 35 help to assist Resident #27 back to bed. She stated she returned to Resident #27's room after NA #1 and NA #2 assisted him back to bed. On 2/4/2022 at 11:30 a.m. in an interview with the Director of Nursing (DON), she stated if Nurse #2 needed help to assist Resident #27 back to bed, Nurse #2 should have turned on the call light, and if no response and resident was safe, Nurse #2 should have stepped out of the room for help. She stated the medication cart could be locked and Nurse #2 should have assisted Resident #27 back in the bed before providing care to Resident #109. The DON stated Resident #27 should not had been left on the floor with no one in the room while waiting for staff to assist him back to the bed.	F 689		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills	F 693		3/15/22

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F 693	Continued From page 36 and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to provide nutritional support through enteral feeding as physician ordered for 1 of 1 resident reviewed for tube feedings. (Resident #50) Findings included: Resident #50 was admitted to the facility on 12/16/2020. His diagnoses included mild protein calorie malnutrition and gastrostomy status. The care plan dated 8/19/2021 revealed Resident #50 had an inadequate nutritional intake. Interventions included maintaining upright position for a specified time after each tube feeding, referring to dietician for evaluations for current nutritional status and determination of formula options, checking placement before mediations and tube feedings and checking residual before initial tube feeding. The physician orders dated 10/04/2021 revealed Resident #50 was ordered fortified nutritional supplement at sixty-five milliliters per hour for twelve hours from eight o'clock in the evening to eight o'clock in the morning via gastrostomy tube. Dietary notes dated 10/8/2021 indicated Resident #50 had experienced a 7.5% weight lost in the last 90 days, no weight change in the last thirty days, and tube feedings were changed to nocturnal (8 p.m. to 8 a.m.) to promote oral	F 693	F693 IMMEDIATE ACTION: On February 4, 2022, the contracted dietician assessed resident #50's nutritional needs. Registered dietician discontinued resident continuous tube feeding order. No further actions taken for resident #50. IDENTIFICATION OF OTHERS: 100% audit of all current residents who are fed by enteral means completed by the Director of Nursing on February 28, 2022, to ensure each resident receive the appropriate feeding as ordered by physician. All other resident who are fed by enteral means noted to receive tube feeding per physician order. Findings of this inspection is documented on a "Tube feeding audit tool" located in the facility compliance binder. SYSTEMIC CHANGES: Effective March 8, 2022, nursing employees that include licensed nurses, and/or trained Medication aides will administer tube feeding to resident who are fed by enteral means based on physician orders. Effective March 8, 2022, all resident who are fed by continuous enteral means will be scheduled to start the feeding at 5pm daily to the stopping time as specified by	

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F 693	Continued From page 37 intake. The significant change Minimum Data Set (MDS) assessment dated 12/1/2021 indicated Resident #50 was cognitively intact, required extensive assistance of one person for eating and had a swallowing disorder. The MDS indicated Resident #50's nutrition was approached with the use of tube feedings, and he received more than fifty one percent of his calories and more than five hundred and one milliliters of fluid intake per day from his tube feedings. Dietary notes dated 1/25/2022 revealed Resident #50 received one can of fortified nutritional supplement if Resident #50 consumed less than fifty percent of each meal, and fortified nutritional supplement at sixty-five milliliters per hour for twelve hours from eight o'clock in the evening to eight o'clock in the morning via gastrostomy tube. Medication Administration Record (MAR) dated February 2022 revealed fortified nutritional supplement at sixty-five milliliters per hour for twelve hours from eight o'clock in the evening to eight o'clock in the morning via gastrostomy tube for identified risk of malnutrition was scheduled for eight p.m. daily. There was no documentation on the MAR indicating the tube feeding has been administered on 2/1/2022 as scheduled. On 2/2/2022 at 7:06 a.m. Resident #50 was observed lying in the bed. There was no tube feeding bag observed on the tube feeding pump and a label reading 8 p.m. to 8 a.m. was observed on the tube feeding pump. Resident #50 stated he did not get his tube feeding during the night.	F 693	an order, unless is contraindicated. This will ensure proper tracking when the feeding is initiated/changed. 100% education of all current Licensed nurses and medication aides to include full time, part time, and as needed employees completed by the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2). The emphasis of this education includes, but not limited to the importance of administering tube feeding to resident who are fed by enteral means based on physician orders and starting/changing tube feeding formula at 5pm unless specified on the order otherwise. This education will be completed by March 15, 2022, Licensed nurses and medication aides not educated by March 15, 2022, will not be allowed to work until educated. This education is added to new hire orientation for all new Licensed nurses and medication aides effective March 8, 2022. MONITORING PROCESS: Effective March 8, 2022, the Director of Nursing, Assistant Director of Nursing, MDS coordinators (#1, #2) and/or Unit Coordinators (#1, #2) will complete monitoring to ensure licensed nurses and/or trained medication aides administer tube feeding to resident who are fed by enteral means based on physician orders and starting/changing tube feeding formula at 5pm unless specified on the order otherwise.	

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F 693	Continued From page 38 On 2/2/2022 at 7:16 a.m. in an interview with Nurse #5, he stated he worked the 7p.m. to 7 a.m. shift on 2/1/2022, and his assignment included Resident #50. He stated Resident #50 was eating food the last time he was assigned to him and stated he did not see an order for Resident #50 to receive a tube feeding on 2/1/2022 and did not hang a tube feeding at 8:00 p.m. on 2/1/2022 for Resident #50. On 2/4/2022 at 11:52 a.m. in an interview with the Director of Nursing, she stated Nurse #5 should have administered the tube feeding as physician ordered for Resident #50.	F 693	This monitoring process will be accomplished by reviewing documentation of all residents who are fed by enteral means to ensure the feeding is administered per physician order. This monitoring process will be completed daily (Monday to Friday) for two weeks, weekly for two more weeks, then monthly for three months, or until the pattern of compliance is established. Effective March 15, 2022, the Director of Nursing and/or assistant Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee (QAPI), for recommendations and/or modifications, monthly for three months, or until the pattern of compliance is achieved. RESPONSIBLE PARTY: Effective March 15, 2022, the Executive Director and the Director of Nursing will be ultimately responsible for the implementation of this plan of correction and ensure that the facility attain and maintain substantial compliance.	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences,	F 695		3/15/22

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F 695	Continued From page 39 and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to display cautionary safety signage indicating the use of oxygen and no smoking for 1 of 1 resident reviewed for respiratory therapy. (Resident #10) Findings included: The facility's policy " Oxygen Safety and Storage" dated 8/2018 stated to post a "No Smoking" sign on the outside of the door to resident's room before starting use of oxygen. Resident #10 was admitted on 04/22/2021, and his diagnoses included chronic obstructive pulmonary disease (COPD). The care plan dated 4/30/2021 revealed Resident #10 was at risk for shortness of breath related to COPD, and interventions included administration of oxygen as physician ordered. The significant change Minimum Data Set (MDS) assessment dated 10/26/2021 indicated Resident #10 was severely cognitively impaired and receiving oxygen. Physician's orders dated 11/10/2021 indicated Resident #10 was ordered oxygen at two liters per minute via nasal cannula. On 1/31/2022 at 11:41 a.m. in the COVID unit, there was no cautionary safety signage related to no smoking or oxygen in use observed on Resident #10's door. Resident #10 was observed lying in the bed receiving two liters per minute of	F 695	F695 IMMEDIATE ACTION: Central supplies coordinator placed cautionary safety signage related to no smoking on Resident #10's door on February 4, 2022. IDENTIFICATION OF OTHERS: 100% inspection of resident's doors, for those who uses Oxygen supplementation, in the facility was completed by the Central supply's coordinator on February 22, 2022, to identify any other resident who uses oxygen without cautionary safety signage related to no smoking on their door. No other door of a resident who uses oxygen supplementation without a no smoking signage noted. Findings of this inspection is documented on a "no smoking sign audit tool" located in the facility compliance binder. SYSTEMIC CHANGES: On February 28, 2022, central supplies coordinator placed extra no smoking signage in each medication room and in the Oxygen room for easy accessibility when oxygen supplementation is initiated per physician order. Effective March 8, 2022, nursing employees that include licensed nurses, Medication aide, and/or Certified nursing aides will post a "No Smoking" sign on the outside of the door to resident's room before starting use of oxygen.	

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oxygen via nasal cannula. Resident #10 was admitted to the COVID unit on 1/25/2022.

On 2/3/2022 at 4:40 p.m. in an interview with Nurse #4, she stated Resident #10 received oxygen due to his COPD and stated there was no posted cautionary safety sign for oxygen in use on the doorway. She stated the doorway was to have a sign stating oxygen was in use and did not know why the cautionary safety signage was not on the doorway.

On 2/4/2022 at 11:44 a.m. in an interview with the Director of Nursing, she stated Resident #10 should have had a cautionary safety sign on his door communicating oxygen was in use. She stated nurses or the central supply coordinator should have placed a cautionary safety sign on Resident #27's doorway.

On 2/4/2022 at 12:02 p.m. in an interview with the Central Supply Coordinator, she stated she gathered oxygen materials and cautionary safety signage when oxygen was ordered for the residents and took the oxygen materials to the resident ' s room and delivered oxygen materials including the cautionary safety signage for oxygen therapy for residents on the COVID unit outside the entrance door. She stated the nursing staff was responsible for connecting to the resident and placing cautionary signage on the doorway in the COVID unit. She stated Resident #10 should have had a cautionary safety sign on his doorway when he was moved from his room to the COVID unit and stated the cautionary safety sign could have been misplaced or not realized by the nursing staff.

F 695

100% education of all current nursing employees to include full time, part time, and as needed employees completed by the Director of Nursing, Assistant Director of Nursing, MDS coordinators (#1, #2) and/or Unit Coordinators (#1, #2). The emphasis of this education includes, but not limited to the importance of placing safety signage related to no smoking to the doors of those residents who use oxygen supplementation. This education will be completed by March 15, 2022. Any nursing employees not educated by March 15, 2022, will not be allowed to work until educated. This education is added to new hire orientation for all new nursing employees effective March 8, 2022.

MONITORING PROCESS:
Effective March 8, 2022, the Director of Nursing, Assistant Director of Nursing, MDS coordinators (#1, #2) and/or Unit Coordinators (#1, #2) will complete monitoring to ensure nursing staff are placing safety signage related to no smoking to the doors of those residents who use oxygen supplementation per policy. This monitoring process will be accomplished by inspecting doors of those residents who use oxygen supplementation to ensure safety signage related to no smoking to the doors. This monitoring will be completed daily (Monday to Friday) for two weeks, weekly for two more weeks, then monthly for three months, or until the pattern of compliance is established.

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F 695	Continued From page 41	F 695	Effective March 15, 2022, the Director of Nursing and/or assistant Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee (QAPI), for recommendations and/or modifications, monthly for three months, or until the pattern of compliance is achieved. RESPONSIBLE PARTY: Effective March 15, 2022, the Executive Director and the Director of Nursing will be ultimately responsible for the implementation of this plan of correction and ensure that the facility attains and maintains substantial compliance.	
F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data	F 732		3/15/22

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F 732	Continued From page 42 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 observations and staff interview, the facility failed to ensure nursing staff data was posted daily. Findings included: During the initial tour of the facility on 1/30/22 at 11:15 AM, the posting of the daily nursing staff data was from 1/27/22. An observation was conducted on 2/2/22 at 9:25 AM and the daily nursing staff data was posted. An interview was conducted with the facility receptionist on 2/2/22 at 9:35 AM who stated the daily nursing staff data was posted by the facility scheduler. An interview was conducted with the scheduler on	F 732	F732 IMMEDIATE ACTION: There was no Resident identified to be affected by this alleged deficient practice. IDENTIFICATION OF OTHERS: Any resident could have been affected by this alleged deficient practice. On February 24, 2022, the facility Staffing coordinator, Executive Director, and/or Director of Nursing completed an audit of current facility staffing sheets for the last 30 days to identify any other day that nursing staffing data were not posted at the beginning of each shift. No other day identified with missing posting of nursing staffing information. Findings of this audit is documented on a “nursing staffing data audit tool” located in the facility	

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F 732	Continued From page 43 2/2/22 at 9:39 AM who stated she was off on 1/28/22 and she changed the daily nursing staff data on 1/31/22. She stated it had not been changed since 1/27/22 and she was not sure who should have changed it while she was off. An interview was conducted with the Administrator on 2/2/22 at 9:43 AM who stated the facility scheduler should have completed the posting for 1/28-1/30/22 prior to being off. During an interview with the scheduler on 2/2/22 at 9:50 AM she stated she was unaware it was her responsibility to post the daily nursing staff data prior to being off.	F 732	compliance binder. SYSTEMIC CHANGES: Effective February 24, 2022, The facility staffing coordinator will post nursing information for four consecutive days at a time on the posting board located at the facility's front lobby. The posting will include the posting day and the following three days. The information posted will be changed as appropriate on a daily basis to reflect the correct number of nursing staff and census at the beginning of each shift by the staffing coordinator, receptionist, nurse manager, manager on duty, and/or the Executive Director. Facility Executive Director completed training with the facility staffing coordinator, receptionist, and nurse managers, and managers on duty on February 24, 2022. The emphasis of the education, including but not limited to, timely posting, documenting accurate census/staffing numbers (licensed & unlicensed staff) and updating of the staffing sheet as needed when changes occur throughout the workday. This education is also added on facility orientation process for any new staffing coordinator, receptionist, nurse managers, and/or managers on duty effective February 24, 2022. MONITORING PROCESS: Effective February 24, 2022, the facility Executive Director and/or Director of Nursing will inspect the "nursing posting board" located at the front lobby to ensure	

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F 732	Continued From page 44	F 732	nursing staffing information is posted for four consecutive days, and contain accurate information based on the staffing numbers and census at the beginning of the inspection shift. This monitoring process will be completed daily Monday through Friday for two weeks, weekly for two more weeks, then monthly for three months or until the pattern of compliance is maintained. Findings of this monitoring process will be documented in nursing staffing monitoring tool located in the facility compliance binder. Effective February 24, 2022, the weekend manager on duty and/or Designated staff will inspect the “nursing posting board” located at the front lobby to ensure nursing staffing information is posted for four consecutive days, and contain accurate information based on the staffing numbers and census at the beginning of the inspection shift. This monitoring process will be completed every Saturday and Sunday for two weeks, every other Saturday and Sunday for two more weeks, then one weekend a month for three months or until the pattern of compliance is maintained. Findings of this monitoring process will be documented in nursing staffing monitoring tool located in the facility compliance binder. Effective March 15, 2022, the Staffing coordinator will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee (QAPI), for recommendations and/or modifications,	

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F 732	Continued From page 45	F 732	monthly for three months, or until the pattern of compliance is achieved. RESPONSIBLE PARTY: Effective March 15, 2022, the Executive Director and the Director of Nursing will be ultimately responsible for the implementation of this plan of correction and ensure that the facility attains and maintains substantial compliance.	
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews the facility failed to ensure a resident's medical appointment was rescheduled for 1 of 1 sampled resident reviewed for medically related social services (Resident # 110). The findings included: Resident #110 was admitted on 12/20/19 with diagnoses that included muscle weakness, diabetes mellitus and hypertension. Review of Resident #110's care plan dated 1/14/22 revealed Resident #110 required staff assistance for all activities of daily living. Resident #110's most recent Minimum Data Set (MDS) assessment dated 1/17/22, a quarterly assessment revealed she was cognitively intact	F 745	F745 IMMEDIATE ACTION: On February 25, 2022, Medical record coordinator (Scheduler) rescheduled appointment for resident #110's medical appointment with a rehab center for ambulation options. New appointment is schedule to happen on March 28,2022. IDENTIFICATION OF OTHERS: 100% audit of current resident clinical documentation, and grievance log for the last three months was completed by medical records coordinator on February 23, 2022, to identify any documented concerns related to missing appointments/cancelled items that were not rescheduled. No other issues were identified during this audit. Findings of this	3/15/22

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F 745

Continued From page 46

with no behaviors. She required extensive assistance with bed mobility, locomotion, dressing, and personal hygiene. She was assessed as dependent for transfers and toilet use.

An interview was conducted with Resident #110 on 1/31/22 at 9:00 AM who stated the facility had cancelled an appointment with a rehab center for ambulation options which was scheduled on 9/28/21 at 3:00 PM. She reported the appointment was not rescheduled.

An interview was conducted with the scheduler on 2/3/22 at 2:52 PM who stated Resident #110's appointment was cancelled by the facility on 9/28/21. She reported Resident #110 was scheduled to be transported by the facility wheelchair van to the appointment. The scheduler further stated the facility van was transporting residents to dialysis and was late returning to the facility so Resident #110's appointment was cancelled. She reported the appointment was not rescheduled and it was an oversight. She indicated she would have been the person to reschedule the appointment.

An interview was conducted with the Administrator of the facility on 2/4/22 at 4:15 PM who stated Resident #110's appointment should have been rescheduled.

F 745

audit is documented on a “Medical appointment audit tool” located in the facility compliance binder.

SYSTEMIC CHANGES:
Effective March 8, 2022, the facility will provide medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident to include ensuring medical related appointments are scheduled and rescheduled in a timely manner.

Effective March 8, 2022, the facility’s clinical team, which includes Director of Nursing, Assistant Director of Nursing, Medical records coordinator, Unit coordinator #1 and/or Unit coordinator #2 initiated a process for reviewing clinical documentation to include the review of medical appointments ordered and/or scheduled in the last 24 hours or from the last held clinical meeting to ensure the appointment is scheduled and take place as ordered. This systemic process will take place daily (Monday through Friday). Any identified issues will be addressed promptly, and appropriate actions will be implemented by the DON, ADON, and/or Unit coordinator #1/#2. Findings of this systemic change will be documented on the daily clinical report form and maintained in the daily clinical meeting binder.

100% education of all current clinical team members to Director of Nursing, Assistant Director of Nursing, Medical records

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F 745	Continued From page 47	F 745	coordinator, Unit coordinator #1 and/or Unit coordinator #2 completed by the Facility Administrator. The emphasis of this education includes, but not limited to, the importance of ensuring each resident receive medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident to include ensuring medical related appointments are scheduled and rescheduled and followed through in a timely manner. The education also emphasized the process of reviewing medical appointment during the daily clinical meeting. This education will be completed by March 15, 2022, any clinical team member not educated by March 15, 2022, will not be allowed to work until educated. This education is added to new hire orientation for all clinical team members effective March 8, 2022. MONITORING PROCESS: Effective March 8, 2022, Director of nursing, Assistant Director of Nursing, and/or Unit coordinator #1 and/or Unit coordinator #2, will monitor compliance with resident's medical appointments by reviewing the daily clinical meeting reports to ensure completion and proper follow through. Any issues identified during this monitoring process will be addressed promptly. This monitoring process will be completed daily Monday through Friday for two weeks, weekly for two more weeks, then monthly for three months or until the pattern of compliance is maintained. Findings of this monitoring	

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F 745	Continued From page 48	F 745	process will be documented on “appointment monitoring form” located in the facility compliance binder. Effective March 15, 2022, the Director of Nursing Assistant, Director of Nursing, and/or medical record coordinator will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee (QAPI), for recommendations and/or modifications, monthly for three months, or until the pattern of compliance is achieved. RESPONSIBLE PARTY: Effective March 15, 2022, the Executive Director and the Medical Records Coordinator will be ultimately responsible for the implementation of this plan of correction and ensure that the facility attains and maintains substantial compliance.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable	F 812		3/15/22

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F 812	Continued From page 49 safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to label, date, and close food items that have been opened and stored in the in the refrigerator and freezer in one of two observations in the facility kitchen. The findings included: In observation of the facility kitchen conducted with the morning cook in attendance on 1/30/2022 at 12:58 PM, the refrigerator was observed to contain the following items: 1. One gallon of opened mayonnaise that was opened but had no date to indicate when it had been originally opened. 2. One 12-ounce package of sliced bologna that was opened but had no date to indicate when it was originally opened, and the package was open to air in the refrigerator. In observation of the facility kitchen conducted with the morning cook in attendance on 1/30/2022 at 1:14 PM, the freezer was observed to contain the following items: 1. One 20-lb. box of mixed vegetables that was opened and dated but had not been closed or re-sealed and was open to air in the freezer. 2. One 10-lb. box of sausage patties that was opened and dated but had not been closed or re-sealed and was open to air in the freezer.	F 812	F 812 IMMEDIATE ACTION: Dietary Manager discarded all identified open undated items and all dated items that were observed to be open to air in refrigerator on January 30, 2022. The items discarded included: One gallon of opened mayonnaise that was opened but had no date to indicate when it had been originally opened, One 12-ounce package of sliced bologna that was opened but had no date to indicate when it was originally opened, One 20-lb. box of mixed vegetables that was opened and dated but had not been closed or re-sealed in the freezer, and One 10-lb. box of sausage patties that were opened and dated but had not been closed or re-sealed and was open to air in the freezer. IDENTIFICATION OF OTHERS: All residents have a potential to be affected by this practice, therefore an audit of the entire kitchen was completed a Dietary Manager on February 25, 2022, to identify any food item/s with no label, date, and/or any food items that have been opened and stored in the in the refrigerator and freezer without being	

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F 812	Continued From page 50 An interview with the dietary manager was conducted on 1/31/2022 at 2:15 PM and revealed that all dietary staff are instructed that opened food items should be labeled, dated, and closed or re-sealed. She reported food items that have been opened should be labeled and dated with the date the item was originally opened. She also reported that opened food items should be closed or re-sealed so they are protected from the air in the refrigerator or freezer.	F 812	closed. Findings of this audit is documented on a “Kitchen inspection audit tool located in the facility compliance binder. SYSTEMIC CHANGES: On February 28, 2022, the facility Dietary Manager re-established a cleaning assignment for dietary staff on duty to ensure the kitchen food storage locations, to include refrigerators, freezers, and dry storage areas, are cleaned and all open food items have labels with dates and are closed when food items have been opened and stored in the refrigerator and freezer. The new cleaning assignment will be used effective February 28, 2022. 100% education of all active/current facility Dietary employees to include full time, part time, and as needed employees will be completed by the Dietary Manager. The emphasis of this education includes, but not limited to the importance of ensuring the kitchen food storage locations, to include refrigerators, freezers, and dry storage areas, are cleaned and all open food items include labels with dates and are closed when food items have been opened and stored in the refrigerator and freezer. This education will be completed by March 15, 2022. Any dietary employee not educated by March 15, 2022, will not be allowed to work until educated. This education will be provided annually and will be added to new hire orientation for all new dietary employee employees effective March 8, 2022.	

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F 812	Continued From page 51	F 812	MONITORING PROCESS: Effective March 8, 2022, the Dietary Manager will complete a kitchen monitoring process to ensure the kitchen food storage locations, to include refrigerators, freezers, and dry storage areas, are clean and all open food items include labels with dates and are closed when food items have been opened and stored in the refrigerator and freezer. Any negative findings will be corrected promptly. This monitoring process will be completed daily Monday through Friday for two weeks, weekly for two more weeks, then monthly for three months or until the pattern of compliance is maintained. Findings of this monitoring process will be documented on “Food storage monitoring tool” located in the facility compliance binder. Effective February 28, 2022, the cook on duty will complete kitchen monitoring process to ensure the kitchen food storage locations, to include refrigerators, freezers, and dry storage areas, are clean and all open food items include labels with dates and are closed when food items have been opened and stored in the refrigerator and freezer, any negative finding will be corrected promptly. This monitoring process will be completed every Saturday and Sunday for two weeks, every other Saturday and Sunday for two more weeks, then one week end a month for three months or until the pattern of compliance is maintained. Findings of this monitoring process will be	

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F 812	Continued From page 52	F 812	documented on “food storage monitoring tool” located in the facility compliance binder. Effective March 15, 2022, the Dietary Manager and/or Kitchen manager will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee (QAPI), for recommendations and/or modifications, monthly for three months, or until the pattern of compliance is achieved. RESPONSIBLE PARTY: Effective March 15, 2022, the Executive Director and the Dietary Manager will be ultimately responsible for the implementation of this plan of correction and ensure that the facility attains and maintains substantial compliance.	
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident	F 842		3/15/22

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that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-

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(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews the facility failed to accurately record the blood glucose levels and units of insulin given for 2 of 2 residents (Resident #67 and Resident #95) and failed to document a fall for 1 of 1 resident (Resident #27) reviewed for falls.

The findings included:

1. Resident #67 was admitted to the facility on 2/6/20 with diagnoses that included diabetes mellitus and chronic obstructive pulmonary disease.

Resident #67's quarterly Minimum Data Set (MDS) assessment dated 12/18/21 revealed she was cognitively intact. She had no behaviors or rejection of care.

A physician's order dated 1/4/22 read Accucheck with signs and symptoms use NovoLog insulin for blood sugar greater than 200:
201-250=5 units
251-300=8 units
301-250=12 units
351-400=16 units

F 842

F642
IMMEDIATE ACTION:
Resident #67 was seen by a Nurse Practitioner on February 14, 2022, a new order was received to discontinue accuchecks with sliding scale and to start accuchecks without sliding scale twice daily.

Resident #95 was seen by a Nurse Practitioner on February 28, 2022, a clarification order was received for accuchecks with sliding scale that contain a place to document blood glucose obtained and entered in electronic health records by the Director of Nursing.

Nurse #2 documented in the medical record for resident #27 on February 4, 2022 “a late entry documentation” that included an assisted fall that happened on January 31, 2022.

IDENTIFICATION OF OTHERS:
100% audit of all current residents with orders for accuchecks completed on

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F 842	Continued From page 55 Call physician for blood sugar greater than 400 or less than 60. Review of Resident #67's Medication Administration Record (MAR) for January 2022 revealed Resident #67 received 133 units of insulin on 1/5/22, 136 units of insulin on 1/6/22, 202 units of insulin on 1/11/22, 130 units of insulin on 1/17/22, 124 units of insulin on 1/18/22, 145 units of insulin on 1/20/22, and 136 units on 1/22/22. An interview with the Unit Manager on 2/2/22 at 4:00 PM revealed the documentation was incorrect. She indicated the units of insulin were the same as the Resident's blood glucose level. The Unit Manager stated she was unsure how this occurred. She further stated she was certain the insulin was not administered however the documentation reflected insulin was administered. During an interview with Nurse #6 who frequently works on the medication cart was conducted on 2/2/22 at 5:45 PM revealed there was an issue with the system. Nurse #6 information from blood glucose testing that number is automatically populated into insulin administered. She stated she and the other nurses should have deleted that information from the system, and she neglected to do so. She indicated she had not reported this issue to anyone. An interview with the Director of Nursing on 2/3/22 at 3:30 PM revealed the documentation was incorrect and nurses on the medication cart should have advised her of any problems with the computer system.	F 842	February 28, 2022, March 1,2022 and March 2,2022 by Director of Nursing, Unit coordinator #1, and/or Unit coordinator #2 to identify any other resident with an accucheck order that was entered in the system without a place to document blood glucose correctly. Identified orders that were entered incorrectly were corrected by the Director of Nursing, Unit coordinator #1, and/or Unit manager #2. Findings of this audit is documented on an “Accucheck audit tool” located in the facility compliance binder. 100% audit of all incident reports written in the last 30 days completed on February 28, 2022, by Director of Nursing, Unit coordinator #1, and/or Unit coordinator #2 to identify any other incidence of fall or assisted fall not documented in medical records. No other incidents/accidents were identified not documented in medical records. Findings of this audit is documented on an “Incident report audit tool” located in the facility compliance binder. SYSTEMIC CHANGES: Effective March 8, 2022, licensed nurses and medication aides will document on the medication administration records that insulin was not administered when blood sugar is below qualifying sliding scale value. This will allow Licensed nurses and medication aides to document the blood sugar on the correct prompt and not as unit of insulin. Effective March 8, 2022, the Director of nursing set the parameter that will	

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2.. Resident #95 was admitted to the facility on 8/26/21 with diagnoses that included diabetes mellitus and hypertension.

Resident #95's significant change MDS assessment dated 1/8/22 revealed he was assessed as having a severe cognitive impairment. He had no behaviors or rejection of care. He received insulin injections 7 of 7 days of the lookback period.

A physician's order dated 9/27/21 read Accucheck with signs and symptoms use NovoLog insulin for blood sugar greater than 200:
201-250=5 units
251-300=8 units
301-250=12 units
351-400=16 units
Call physician for blood sugar greater than 400 or less than 60.

Review of Resident #95's Medication Administration Record (MAR) for January 2022 revealed Resident #95 received 154 units of insulin on 1/2/22, 171 units of insulin on 1/4/22, 173 units of insulin on 1/5/22, 176 units of insulin and 195 units of insulin on 1/6/22, 130 units of insulin and 212 units of insulin on 1/7/22, 217 units on insulin on 1/10/22, 204 units of insulin on 1/12/22, 107 units of insulin 0n 1/16/22, 148 units of insulin on 1/18/22, and 218 units of insulin on 1/24/22.

An interview with the Unit Manager on 2/2/22 at 4:00 PM revealed the documentation was incorrect. She indicated the units of insulin were the same as the Resident's blood glucose level. The Unit Manager stated she was unsure how this occurred. She further stated she was certain

F 842

automatically transfer the details of incident report entered in "incident report module" to automatically transfer to the facility's clinical documentation to ensure each incident is documented at the same time when an incident report is entered.
100% education of all current Licensed nurses and Medication aides, to include full time, part time and as needed employees completed by the Director of Nursing, Assistant Director of Nursing, Unit coordinator #1 and/or Unit coordinator #2. The emphasis of this education includes, but not limited to, the importance of entering accucheck orders currently in Electronic Medical Records, documenting on medication administration records that insulin was not administered when blood sugar is below qualifying sliding scale value for applicable residents, and/or ensuring that each incident/accident to include assisted falls are documented on each resident electronic medical records.

This education will be completed by March 15, 2022. Any Licensed nurses and/or Medication aide not educated by March 15, 2022, will not be allowed to work until educated. This education is added to new hire orientation for all Licensed nurses and Medication aides effective March 8, 2022.

MONITORING PROCESS:
Effective March 8, 2022, Director of nursing, Assistant Director of Nursing, and/or Unit coordinator #1 and/or Unit coordinator #2, will monitor compliance by

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the insulin was not administered however the documentation reflected insulin was administered.

During an interview with Nurse #6 who frequently works on the medication cart was conducted on 2/2/22 at 5:45 PM revealed there was an issue with the system. Nurse #6 information from blood glucose testing that number is automatically populated into insulin administered. She stated she and the other nurses should have deleted that information from the system, and she neglected to do so. She indicated she had not reported this issue to anyone.

An interview with the Director of Nursing on 2/3/22 at 3:30 PM revealed the documentation was incorrect and nurses on the medication cart should have advised her of any problems with the computer system.

3. Resident #27 was admitted to the facility on 3/3/2021. His diagnoses include difficulty walking and unsteadiness on feet.

The care plan dated 3/10/2021 revealed Resident #27 was at risk for falls and injury related to weakness and impaired mobility. Interventions included bed in low position, resident in the center of the bed, encouraging the use of the call light to request assistance, arranging furniture in his reach, and monitoring for changes in condition that may warrant increased supervision and assistance and notifying the physician.

F 842

reviewing all new orders, Medication Administration records for residents with orders for accucheck with sliding scale, and incident reports written from the prior clinical meeting to ensure all accucheck orders are entered correctly, documented accurately in medication Administration records, and incident/accidents are documented in medical records. Any issues identified during this monitoring process will be addressed promptly. This monitoring process will be completed daily Monday through Friday for two weeks, weekly for two more weeks, then monthly for three months or until the pattern of compliance is maintained. Findings of this monitoring process will be documented on “clinical documentation monitoring form” located in the facility compliance binder.

Effective March 15, 2022, the Director of Nursing and/or Assistant Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee (QAPI), for recommendations and/or modifications, monthly for three months, or until the pattern of compliance is achieved.

RESPONSIBLE PARTY:
Effective March 15, 2022, the Executive Director and the Director of Nursing will be responsible for the implementation of this plan of correction and ensure that the facility attains and maintains substantial compliance.

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The admission Minimum Data Set (MDS) assessment dated 3/12/2021 indicated Resident #27 was severely cognitively impaired with impairments to both lower extremities and indicated no history of falls. The 5-day MDS dated 1/25/22 revealed Resident #27 was severely cognitively impaired with impairments to both upper and lower extremities and had experienced two or more falls without injury.

On 1/31/2022 at 10:03 a.m., Resident #27 was observed with his head and upper body on the floor, his waist was over the edge of the bed and his feet and legs were on the bed when entering his room. The bed was positioned low to the floor. Nurse #2 was called to Resident #27's room. Nurse #2 was observed entering the Resident #27's room, assisting him to the floor and exiting the room. On 1/31/2022 at 10:08 a.m., Nurse Aide (NA) #1 and NA #2 were observed entering Resident #27's room to assist him back into the bed. Nurse #2 was not observed re-entering Resident #27's room.

Review of the medical record revealed no documentation of a fall for Resident #27 on 1/31/2022.

On 2/4/2022 at 11:00 a.m. in an interview with Nurse #2 , she stated on 1/31/2022 Resident #27 was trying to get out of the bed, and she assisted him to the floor. She stated since she assisted him to the floor, she did not consider it a fall. Nurse #2 further stated she did not document the incident in the nursing notes or complete any incident report. Nurse #2 further stated she did not know the facility's procedures after a fall.

On 2/4/2022 at 11:30 a.m. in an interview with the

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F 842	Continued From page 59 Director of Nursing, she stated Resident #27 being on the floor was considered a fall, and Nurse #2 should had documented the fall in the nursing progress notes in Resident #27's medical record and completed an incident report.	F 842		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention 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;	F 880		3/15/22

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F 880	Continued From page 60 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to adhere to infection control measures related to COVID-19 when Nurse #2 was observed not donning a gown or gloves	F 880	F880 ROOT CAUSE ANALYSIS (RCA) The Governing body led by the facility Administrator and Director of Nursing in	

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when providing resident care to 1 of 1 residents (Resident # 371) in the hallway and before entering the rooms for 2 of 2 residents (Resident #109, Resident #63) residing in the COVID-19 unit. This occurred during a COVID pandemic.

Findings Included:

On 1/30/2022 at 3:12 p.m. enhanced droplet-contact precaution signage and donning and doffing personal protective equipment (PPE) signage was observed on the doors of the residents in the COVID unit.

On 1/31/2022 at 10:09 a.m., Resident #371 was observed in a wheelchair at the medication cart. Nurse #2 was observed wearing N-95 mask and not wearing goggles, gown or gloves when administering Resident #371 his medications and taking his blood pressure in the hallway on the COVID unit.

On 1/31/2022 at 10:12 a.m., Nurse #2 was observed entering Resident #109's room wearing goggles and N-95 and not applying a gown or gloves before entering the room.

On 1/31/2022 at 10:14 a.m., Nurse #2 was observed entering Resident #63's room wearing N-95 mask and goggles and not wearing a gown or gloves. Nurse #2 was observed performing an oxygen saturation and temperature on Resident #63 and exiting the room.

On 1/31/2022 at 10:16 a.m. in an interview with Nurse #2, she stated the residents were on droplet precautions for COVID-19, and gloves, gowns, N-95 and goggles were required when entering the resident ' s rooms. She stated she

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collaboration with the facility Infection Preventionist and Quality Assurance and Performance Improvement (QAPI) committee conducted the root cause analysis on February 24, 2022, to identify the causative factor for this alleged noncompliance and implemented appropriate measures to correct and prevent the reoccurrences of the alleged noncompliance. The root cause analysis identified that the alleged noncompliance resulted from the failure of one facility employee (Nurse #2) to adhere to the facility infection prevention policy and procedures related to the needs of Personal Protective Equipment use in the COVID unit. The RCA further identified that the facility failed to ensure increased vigilance and supervision to ensure infection prevention policies and procedures are followed in the entire facility to include the COVID unit.

IMMEDIATE ACTION:
Director of nursing assessed resident #63, #371, and resident #109 on February 24, 2022, no negative outcome noted following this alleged noncompliance.

IDENTIFICATION OF OTHERS
All residents have a potential to be affected by this alleged noncompliance

SYSTEMIC CHANGES
Effective March 8, 2022, The governing body including (in parts): the Facility Administrator, Director of nursing, and/or Infection preventionist developed a process that will increase vigilance and

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F 880	Continued From page 62 had received education on the use of personal protective equipment for COVID residents and did not have a reason why she did not apply gown and gloves before entering resident rooms or providing care to the residents on the COVID unit. On 2/1/2022 at 2:28 p.m. in an interview Administrator, Assistant Administrator and Director of Nursing/Infection Preventionist present, the Administrator stated N-95 mask, eye protective wear, gown and gloves were required before entering resident ' s rooms on the COVID unit.	F 880	supervision to facility staff through increased infection control surveillance rounding to ensure personal protective equipment are adhered throughout the facility to include COVID unit. The new process will require designated department heads to conduct infection control surveillance round by randomly observing five employees weekly and document findings on a PPE compliance form. Any issues identified during this process will be addressed promptly. On February 28, 2022, the facilities Governing body, which includes (in parts), Administrator, Director of nursing, and infection preventionist, developed a process that will ensure an increased vigilance and supervision of the facility staff to ensure PPE compliance including compliance with PPE in the COVID unit. In the developed process, the Scheduling Coordinator and/or Director of Nursing will designate one Licensed nurse on each shift in the COVID unit to aide on ensuring the PPE compliance takes place. Scheduling coordinator will indicate on the daily nursing assignment who the designated nurse is for that shift for proper communication effective February 28, 2022. Effective March 8, 2022, the designated licensed nurse will ensure staff members wear their PPEs per facility policy and procedures. Any identified issues will be addressed promptly, and appropriate actions will be implemented by the Designated nurse, Director of Nursing and/or infection preventionist.	

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F 880	Continued From page 63	F 880	Effective March 8, 2022, the designated nurse will document any break down of infection prevention measures noted in the COVID unit in a COVID unit report form that will be given to the facility infection preventionist and/or Director of nursing for further measures as appropriate. Director of Nursing (DON) will complete 100% education for all employees in the facility to include full time, part time, and as needed employees. The emphasis of this education includes, but not limited to the importance of the functions of the designated nurse to enforce PPE adherence in the COVID unit, ensuring proper wear of PPE (mask covering nose and mouth, gown, gloves, and goggles when applicable) always while in patient care areas, and the importance of following infection control practices to keep COVID out of the facility and/or manage it effectively in the facility. The Director if nursing uses Keep COVID out training video recommended by CDC as part of this training. This education will be completed by March 15, 2022. Any employee not educated by March 15, 2022, will not be allowed to work until educated. This education is added to new hire orientation for all new hires and will be provided annually effective March 8, 2022. MONITORING PROCESS Effective March 8, 2022, The Facility Administrator, Director of nursing,	

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F 880	Continued From page 64	F 880	Infection preventionist, and/or designated administrative staff, will monitor compliance with infection control surveillance rounding by reviewing the completion of PPE compliance tool (used to conduct surveillance rounds), from previous day/days to ensure all employees used proper PPE per facility policy. Any issues identified during this monitoring process will be addressed promptly. This monitoring process will be conducted daily for two weeks, weekly for two more weeks, then monthly for three months or until a pattern of compliance is achieved. Effective March 8, 2022, The Facility Administrator, Director of nursing, Infection preventionist, and/or designated administrative staff will monitor compliance with proper PPE use by reviewing the COVID unit report form completed for the previous day/days to ensure all employees used proper PPE per facility policy. Any issues identified during this monitoring process will be addressed promptly. This monitoring process will be conducted daily for two weeks, weekly for two more weeks, then monthly for three months or until a pattern of compliance is achieved. Effective March 8, 2022, the facility Director of nursing and/or infection preventionist will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until	

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F 880	Continued From page 65	F 880	a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. RESPONSIBLE PARTY: Effective March 15, 2022, the Executive Director and the Director of Nursing will be ultimately responsible for the implementation of this plan of correction and ensure that the facility attains and maintains substantial compliance.	
F 885 SS=B	Reporting-Residents,Representatives&Families CFR(s): 483.80(g)(3)(i)-(iii) §483.80(g) COVID-19 reporting. The facility must— §483.80(g)(3) Inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. This information must— (i) Not include personally identifiable information; (ii) Include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered; and (iii) Include any cumulative updates for residents, their representatives, and families at least weekly or by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with	F 885		3/15/22

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F 885	Continued From page 66 new onset of respiratory symptoms occur within 72 hours of each other. This REQUIREMENT is not met as evidenced by: Based on record review, Resident Representative and staff interview, the facility failed to inform resident representatives and/or families for ten residents, (Resident #93, #60, #29, #111, #7, #14 #81, #89, #70 and #76), by 5:00 PM the next calendar day following the occurrence of a confirmed COVID-19 infection for 1 of 1 staff reviewed for COVID-19 testing for 12/13/2021. Findings Included: Review of the COVID-19 testing log revealed 1 staff tested positive on 12/13/2021. A review of the facility's Ambassador assignment list revealed the Dietary Manager was assigned to rooms 406A-410B and was responsible for notifying resident representatives and families of the status of COVID-19 positives at the facility involving staff and/or residents. An interview with Resident #93's representative on 01/31/2022 at 11:27 AM revealed she hadn't been notified by the facility for "about a month" regarding how many cases of COVID-19 were in the building. An interview with the Administrator on 02/02/2022 at 3:37 PM revealed the facility designated Ambassadors to assigned resident rooms. He stated the Ambassadors were responsible for calling and notifying families and their representatives of positive COVID-19 cases in the building for their assigned rooms. He also	F 885	F885 IMMEDIATE ACTION: Director of Nursing informed resident # 93s representative on the COVID-19 status of the facility on February 24, 2022. IDENTIFICATION OF OTHERS 100% audit of all current residents clinical documentation, and Ambassador communication sheets, with dates December 13, 2021, and December 14, 2021, completed by the Director of Nursing, Assistant Director of Nursing, Unit Manager #1, and/or Unit Manager #2 to determine whether all residents representatives were notified of the occurrence of confirmed COVID-19 infection from testing conducted on 12/13/2021. Those identified without documented notification were notified promptly by Director of Nursing, Assistant Director of Nursing, Unit Manager #1, and/or Unit Manager #2 on February 24, 2022. This audit was completed on February 24, 2022. Findings of this audit are documented on COCID notification audit tool located in the facility compliance binder. SYSTEMIC CHANGES Effective March 8, 2022, and moving forward, the facility will inform residents and their representatives by 5 pm next calendar day following the occurrence of any confirmed COVID-19 infection in the	

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	345213	A. BUILDING ______ B. WING ______	C 02/04/2022

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F 885	Continued From page 67 stated the Dietary Manager was assigned to rooms 406a-410B and had stop working at the facility in late December 2021. The Administrator stated the facility did not reassign Resident #93's room to another staff member after the Dietary Manager stopped working at the facility. The Administrator stated the facility failed to notify families and representatives for the assigned room numbers of 406A-410B regarding a staff member that tested positive for Covid-19 on 12/13/2021.	F 885	facility. On February 24, 2022, the facility Administrator revised the Ambassador assignment to include a backup ambassadors and floating Ambassadors. This new assignment will be used effective February 28, 2022. The backup ambassador will be responsible to carry out all the responsibilities of the assigned ambassador when the assigned ambassador is absent, while the floating ambassador will be taking the responsibility only in the absence of the assigned, and back up ambassadors effective March 8, 2022. Effective March 8,2022, the Assigned ambassador, back up ambassador, licensed nurse on duty, and/or the floating ambassadors will inform residents and their representatives by 5 pm next calendar day following the occurrence of any confirmed COVID-19 infection and document the notification on the resident□s medical records or Ambassador communication sheets maintained in the Ambassador binder in the Administrator□s office. The Facility Administrator, Director of Nursing (DON), Assistant Director of Nursing and/or unit managers will complete 100% education for all ambassadors and licensed nurses to include full time, part time and as needed staff. The emphasis of this education was on the importance of informing residents and their representatives by 5 pm next	

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F 885	Continued From page 68	F 885	calendar day following the occurrence of any confirmed COVID-19 infection in the facility. This education will be completed by March 15,2022. Any Licensed Nurse or Ambassador not educated by March 15, 2022, will not be allowed to work until educated. This education will also be added on new hires orientation process for all new licensed nurses and ambassadors and will also be provided annually effective March 15, 2022 MONITORING PROCESS Effective March 15, 2022, The administrator, Director of Nursing and/or Assistant Director of Nursing, will monitor compliance with COVID-19 notification to residents representative by 5 pm next calendar day following the occurrence of any confirmed COVID-19 infection in the facility. This monitoring process will be accomplished by reviewing the documentation of notification following a new case of COVID 19 in the facility in either resident s medical records and/or ambassador communication sheets. Any issues identified during this monitoring process will be addressed promptly. Findings from this monitoring process will be documented on a COVID 19 reporting monitoring tool located in the facility compliance binder. This monitoring process will take place daily for 2 weeks, weekly x 2 more weeks, then monthly x 3 months or until the pattern of compliance is achieved. Effective March 15, 2022, the Director of Nursing and/or assistant Director of	

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F 885	Continued From page 69	F 885	Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee (QAPI), for recommendations and/or modifications, monthly for three months, or until the pattern of compliance is achieved established. RESPONSIBLE PARTY: Effective March 15, 2022, the Executive Director and the Director of Nursing will be ultimately responsible for the implementation of this plan of correction and ensure that the facility attains and maintains substantial compliance.	
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to maintain a sanitary environment by having cigarette butts scattered throughout the courtyard and smoking areas and failed to post designated smoking area signs in the deemed smoking areas. Findings Included: Review of facility policy's smoking policy, "Resident Smoking, Smoke Free Facility," dated February 2021 revealed under "Procedure", number #4, stated in part: "Smoking is only	F 921	F921 IMMEDIATE ACTION: House Keeping Manager cleaned the courtyard and removed all cigarette butts from the ground in the courtyard on February 03, 2022. Maintenance Director placed “designated smoking area” signs in the appropriate areas of the courtyard that designated as smoking areas on February 28, 2022. Maintenance Director also removed “No smoking signs” from the designated	3/15/22

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F 921	Continued From page 70 allowed in designated resident smoking areas located outside of the building. "Designated Smoking Area" signs would be prominently posted. No signs were observed that stated "Designated Smoking Area" for Hall #1 and Hall #5 in the deemed smoking areas. An observation of the facility's smoking area on 02/03/2022 09:30 AM revealed 4 entrances and 4 exits. Continued observation also revealed 30 cigarette butts gathered in a section of the facility's courtyard called "Hall # 4" and a "No Smoking" sign was posted above the entrance/exit door and there were scattered cigarette butts, approximately 28 in count, throughout the courtyard on all four sections, two of which had "No Smoking" signage posted above the entrance/exit doors. An interview with the facility's Social Worker on 02/02/2022 at 9:31 AM who was in the courtyard of the facility at the time of interview, revealed the facility's deemed smoking areas inside the courtyard were "Hall #1 and Hall #5." The facility's no smoking areas were "Hall #4 and Hall #7." The Social Worker also stated she thought housekeeping and maintenance were responsible for cleaning the courtyard area and acknowledged the cigarettes butts should not be on the ground but should be disposed in a collection container and disposed in a secure trash can. She also stated she was in the courtyard to oversee the residents who were smoking at the time of this observation. One resident was observed outside smoking at the time of this interview. No signs were observed that stated "Designated Smoking Area" for Hall #1 and Hall #5 in the deemed smoking areas. An interview with the Maintenance Director on 02/03/22 11:26 AM revealed the housekeeping	F 921	smoking areas on February 28, 2022. IDENTIFICATION OF OTHERS: 100% inspection of the courtyard areas and outside facility grounds were performed on February 22, 2022, by the Housekeeping Manager to identify any other areas with cigarette butts on the ground. No other areas were identified with cigarettes butts on the ground. Findings of this inspection is documented on an “environmental services” audit tool located in the facility compliance binder. SYSTEMIC CHANGES: On February 28, 2022, the facility House Keeping Manager re-established a cleaning assignment for housekeeping staff on duty to ensure the facility courtyard is cleaned and sanitized daily. The new cleaning assignment will be used effective February 24, 2022. Effective February 28, 2022, employees, residents, and visitors will be allowed to smoke in areas with a posted sign “designated smoking area only”. Anyone observed smoking in an undesignated smoking area will be redirected and appropriate measures will be taken immediately for violating the facility smoking policy. 100% education of all active/current facility House Keeping, and laundry employees to include full time, part time, and as needed employees will be completed by the House keeping manager. The emphasis of this education	

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F 921 Continued From page 71

department cleaned the courtyard on Mondays and Thursdays. The Maintenance Director stated his department did not clean the courtyard.

An interview with a housekeeper on 02/02/2022 at 11:41 AM revealed the courtyard was cleaned twice a week on Mondays and Thursdays.

An interview with the Administrator on 02/02/2022 at 11:52 AM revealed he was unaware that residents were smoking in the courtyard "no smoking areas" and all staff had been educated to redirect residents who were observed smoking beyond the deemed smoking areas. He added there should not have been cigarette butts on the ground in the courtyard area and housekeeping staff were responsible for cleaning the courtyard. The Administrator added there were "No Smoking signs above the entrances/exits of "Hall #4 and Hall #7" and there were no signs that stated, "Designated Smoking Area" per facility policy.

F 921

includes, but not limited to the importance of ensuring the courtyard is free of cigarette butts, the new house keeping cleaning schedule, and to ensure the facility is clean and sanitary for residents, staff, and the public. This education will be completed by March 15, 2022. Any housekeeping/laundry employee not educated by March 15, 2022, will not be allowed to work until educated. This education will be provided annually and will be added to new hire orientation for all new housekeeping/laundry employee employees effective March 8, 2022.

MONITORING PROCESS:
Effective March 8, 2022, the Housekeeping Manager will complete environmental rounds monitoring process to ensure the facility is clean and sanitary for residents, staff, and the public. This will be done by inspecting the courtyard to ensure it is without cigarette butts on the ground, ensure the new cleaning assignment is adhered to by the House keeping staff. Any negative findings will be corrected promptly. This monitoring process will be completed daily Monday through Friday for two weeks, weekly for two more weeks, then monthly for three months or until the pattern of compliance is maintained. Findings of this monitoring process will be documented on the “environmental rounds monitoring tool” located in the facility compliance binder.

Effective February 28, 2022, the weekend manager on duty and/or Designated staff will complete environmental rounds

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F 921	Continued From page 72	F 921	monitoring process to ensure the facility is clean and sanitary for residents, staff, and the public by inspecting the courtyard to ensure it is without cigarette butts on the ground and ensure the new cleaning assignment is adhered by the House keeping staff. Any negative findings will be corrected promptly. This monitoring process will be completed every Saturday and Sunday for two weeks, every other Saturday and Sunday for two more weeks, then one weekend a month for three months or until the pattern of compliance is maintained. Findings of this monitoring process will be documented on the “environmental rounds monitoring tool” located in the facility compliance binder. Effective March 15, 2022, the House Keeping Manager and/or Maintenance Director will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee (QAPI), for recommendations and/or modifications, monthly for three months, or until the pattern of compliance is achieved. RESPONSIBLE PARTY: Effective March 15, 2022, the Executive Director and the House Keeping Manager will be ultimately responsible for the implementation of this plan of correction and ensure that the facility attains and maintains substantial compliance.	