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	345179	A. BUILDING _____ B. WING _____	C 04/29/2022

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ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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 COVID-19 Focused Survey was conducted on 04/25/22 through 04/29/22. The faciltiy was found to be in compliance with 42 CFR 483.73 related to E-0024 (b)(6), Subpart B-Requirements for Long Term Care Facilities. Event ID #C3YV11.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and complaint investigation were conducted on 04/25/22 through 04/29/22. The facility was found out of compliance with 42 CFR 483.80 infection control. There were 51 allegations investigated and 7 were substantiated. NC00186638, NC00185956, NC00185978, NC00185953, NC00185955, NC00185962, NC00185685, NC00185520, NC00185519, NC00185479, NC00185477, NC00184006, NC00184023, NC00182892, NC00181292, NC00181262, NC00186797, NC00186770. Past Non-Compliance was identified at: CFR 483.25 at F689 at a scope and severity of J. The tag F689 constitued Substandard Quality of care. A partial extended survey was conducted on 04/28/22 and 04/29/22.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and	F 584		5/28/22

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

Electronically Signed | 05/18/2022

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F 584	Continued From page 1 supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility: 1) failed to ensure baseboard was in good	F 584	1.Room # 112-bathroom baseboard and the hole in the wall behind the door was	

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F 584	Continued From page 2 repair in 1 of 6 resident bathrooms (Room #112); 2) failed to maintain a homelike environment in 4 of 31 resident rooms/bathrooms (Room #112, #204, #301, and #308) observed to have damaged and splintered wooden wall borders and doors, scuff marks and peeling sheetrock on the walls, and holes in the wall and back of a room door; 3) failed to clean a bathroom with a strong odor of urine in 1 of 6 resident bathrooms (Room #300) on 3 of 4 resident halls (100 Hall, 200 Hall, and 300 Hall). Findings included: 1. An observation of Room #112 was conducted on 04/25/22 at 10:20 AM. On the wall, just behind the room door, was a hole in the wall the approximate size of the doorknob. In the bathroom, the baseboard along the entire perimeter had detached from the wall and was lying on the floor. Subsequent observations conducted on 04/26/22 at 5:36 PM and 04/28/22 at 2:27 PM revealed the conditions remained unchanged. An observation of Room #112 and interview was conducted with the Maintenance Director on 04/29/22 at 3:15 PM. The Maintenance Director stated he wasn't aware of the hole in the wall behind the room door or that the baseboard had detached along the perimeter of the bathroom walls. He stated staff should have notified him of the repairs that were needed so that they could have been fixed. The Maintenance Director explained a clipboard with paper forms were kept at each nurse station for staff to fill out for repairs needed or they could verbally tell either him or the Maintenance Assistant.	F 584	repaired by 5/27/22 by the Maintenance Director. Rooms #308 the wood border along the bottom of the wall and splintered wood damage was repaired by the Maintenance Director by 5/27/22 Room #301-bathroom hole in the lower portion of the door, the scuff marks, the crayon marks behind the toilet and the unpainted and peeling sheetrock was repaired by the Maintenance Director on by 5/27/22. Room #300 was deep cleaned by Environmental Services including the bathroom and the buildup of black debris on the lid of the toilet on by 5/27/22 Room #204 damage to the sheet rock along side the bed and the scuff marks was repaired by the Maintenance Director on by 5/27/22 2. All resident rooms have the potential to be affected. Environmental rounds were completed by the Department Managers on 5/20/2022 to ensure that the facility provides a safe, clean, homelike environment. The facility will address any identified concerns by 5/27/22. 3.Staff to include agency staff will be educated on the work order system by the Assistant Director of Nursing/ designee by 5/27/22. Any newly hired staff and/or agency staff will also be educated on the work order system and will not be allowed to work until the education is completed. 4. Maintenance Director/ designee will audit 5 rooms weekly for 4 weeks and monthly for 2 months to ensure the facility continues to maintain a safe, clean, comfortable, homelike environment of the	

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F 584	Continued From page 3 During an interview on 04/29/22 at 12:54 PM, the Administrator was unaware of the environmental concerns observed in Room #112 and explained educating staff on completing work orders for maintenance was a work in progress. The Administrator stated she would expect for staff to notify maintenance when repairs were needed. 2. An observation was made on 04/27/22 at 8:33 AM of room 308. A wooden border along the bottom part of the wall had several areas of damaged and splintered wood. An interview was conducted on 04/29/22 at 12:53 PM with the Administrator. The Administrator stated she would expect damaged walls would be reported and repaired timely and for staff to notify maintenance when repairs were needed. An observation and interview were conducted on 04/29/22 at 1:33 PM with the Maintenance Director. The Maintenance Director noted the damaged and splintered wood and revealed it was unsafe and needed to be repaired to prevent the resident from getting a splinter. The Maintenance Director revealed he was not aware of the damage to wood border. 3. An observation of the bathroom in room 301 was made on 04/27/22 at 2:20 PM. The lower part of the bathroom wall had multiple black and gray colored scuff marks. There was a dried spackled area of sheetrock left unpainted and multiple crayon marks on the wall beside the toilet. There was an area of peeling sheetrock on the wall in front of toilet. The inside of the wooden bathroom door had multiple splinters and a softball sized hole in lower portion of the door. A wash basin and bed pan were placed directly on	F 584	resident rooms. The Maintenance Director/ designee will report findings of the audits to the Quality Assurance Process Improvement (QAPI) committee for at least 3 months for review and will make changes to the plan as necessary to maintain compliance	

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F 584	Continued From page 4	F 584		

the floor under the bathroom sink.

An observation and interview were conducted on 04/28/22 at 3:15 PM with Maintenance Director. The Maintenance Director revealed he wasn't aware of the splinters on the bathroom door or damaged areas on the wall and confirmed the door needed to be fixed to prevent the resident from getting a splinter. The Maintenance Director revealed a paper form was kept at each nurse station used to notify of needed repairs. In the morning the Maintenance Assistant (MA) would pick up the forms and initiate repairs. The Maintenance Director stated anyone who noticed a repair was needed could fill out a form or verbally tell either him or the MA.

An interview and observation were conducted on 04/28/22 at 3:48 PM with Nurse Aide (NA) #6. NA #6 revealed she hadn't noticed the extent of damage to wood door or sheetrock in the bathroom and had not informed maintenance. NA #6 revealed she wasn't aware of a paper form used report repairs to maintenance but could verbally tell them.

An interview was conducted on 04/29/22 at 12:53 PM with the Administrator. The Administrator stated she would expect damaged doors and walls would be reported and repaired timely.

4. An observation of the bathroom in room 300 was made on 04/27/22 at 2:48 PM. The bathroom had a strong odor resembling urine. There was no sign of wetness on the floor. The base of the toilet was discolored with a buildup of black colored debris. The top of toilet bowl was covered with a buildup of debris and lid of the tank had a buildup of dust and both appeared not to be

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F 584	Continued From page 5	F 584		

recently cleaned or wiped off.

An observation of the bathroom in room 300 was made on 04/28/22 at 3:06 PM with the Environmental Service Manager (ESM). The bathroom continued to smell of urine. The base of the toilet continued to have black colored debris and the toilet lid and bowl continued to have a buildup of debris. The ESM confirmed there was odor of urine in the bathroom with no visible sign of wetness on the floor and it appeared the toilet bowl and lid had not been wiped off. The ESM revealed each Housekeeper (HK) was assigned to clean resident rooms each day that included to sweep and mop the bathroom floor and wipe down the surfaces of the toilet. The ESM revealed the HK assigned to clean room 300 had left for the day and indicated the bathroom appeared it wasn't swept, mopped, and the toilet was not cleaned. The ESM stated she would expect that was done before the HK left. The ESM revealed she was not aware of the urine odor in the bathroom and if the odor came from underneath the tile flooring it would need to be replaced to get rid of the odor.

An interview was conducted on 04/29/22 at 12:53 PM with the Administrator. The Administrator stated she would expect the resident's bathrooms to be clean and not smell of urine.

5. An observation of room 204 was made on 04/28/22 at 3:26 PM with the Maintenance Director. The wall along the side of the bed had multiple areas of black and gray colored scuff marks. The Maintenance Director stated he was not aware of the damage to the sheetrock and indicated the bed was too close to the wall and was causing the damage.

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F 584	Continued From page 6 An interview was conducted on 04/29/22 at 12:53 PM with the Administrator. The Administrator stated she would expect damaged walls would be reported and repaired timely.	F 584		
F 640 SS=B	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment.	F 640		5/28/22

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F 640	Continued From page 7 (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to transmit completed Minimum Data Set (MDS) assessments within the regulatory time frame for 6 of 10 sampled residents reviewed for smoking and maintain/improve activities of daily living (Residents #5, #6, #7, #8, #9, and #10). Findings included: 1. Resident #5 was admitted to the facility on 05/07/21. Review of Resident #5's electronic medical record revealed a quarterly MDS assessment dated 01/17/22 was not transmitted to the Centers for Medicare and Medicaid Services until 03/15/22. During an interview on 04/27/22 at 3:39 PM, the	F 640	1.Residents #5, #6, #7, #8, #9and #10 Minimal Data Set (MDS) was reviewed by the MDS Coordinator on 4/26/22related to timely transmission of the MDS assessments within the regulatory time frame. 2. All residents have the potential to be affected. An audit was completed by the MDS Consultant of the MDS in the past 30 days to ensure that MDS assessments are being transmitted within the regulatory time frame on 4/26/22. 3. The MDS Coordinator was provided education by the Regional Clinical Reimbursement Specialist in accordance with the Resident Assessment manual on 4/27/22.	

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F 640	Continued From page 8 MDS Coordinator confirmed Resident #5's completed quarterly MDS assessment dated 01/17/22 was not transmitted within the regulatory time frame. She explained in January 2022, she was out of work for several weeks and there was no one to cover her position. In addition, she stated when she returned to work, she was pulled to do other tasks, such as COVID testing and covering the COVID-19 quarantine unit, which put her further behind on completing and transmitting MDS assessments. During an interview on 04/28/22 at 3:30 PM, the Director of Nursing stated she expected for MDS assessments to be completed and transmitted within the regulatory time frame. During an interview on 04/29/22 at 12:54 PM, the Administrator stated when she started at the facility in March 2022, she was made aware the MDS Coordinator was behind and some MDS assessments had not been completed or transmitted. The Administrator stated she would expect for MDS assessments to be completed and transmitted within the regulatory timeframes. 2. Resident #6 was admitted to the facility on 11/13/19. Review of Resident #6's electronic medical record revealed a quarterly MDS assessment dated 01/27/22 was not transmitted to the Centers for Medicare and Medicaid Services until 03/17/22. During an interview on 04/27/22 at 3:39 PM, the MDS Coordinator confirmed Resident #6's completed quarterly MDS assessment dated 01/27/22 was not transmitted within the regulatory	F 640	4. The MDS Coordinator/ designee complete audits on 5 random MDS assessments weekly for 4 weeks then monthly for 2 months to ensure that MDS are being transmitted within the regulatory timeframe. The MDS Coordinator/ designee will present audits to the Quality Assurance Process Improvement committee for 3 months for review and recommendations. The Administrator will monitor for compliance and follow up as needed.	

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time frame. She explained in January 2022, she was out of work for several weeks and there was no one to cover her position. In addition, she stated when she returned to work, she was pulled to do other tasks, such as COVID testing and covering the COVID-19 quarantine unit, which put her further behind on completing and transmitting MDS assessments.

During an interview on 04/28/22 at 3:30 PM, the Director of Nursing stated she expected for MDS assessments to be completed and transmitted within the regulatory time frame.

During an interview on 04/29/22 at 12:54 PM, the Administrator stated when she started at the facility in March 2022, she was made aware the MDS Coordinator was behind and some MDS assessments had not been completed or transmitted. The Administrator stated she would expect for MDS assessments to be completed and transmitted within the regulatory timeframes.

3. Resident #7 was admitted to the facility on 04/07/21.

Review of Resident #7's electronic medical record revealed a quarterly MDS assessment dated 01/28/22 was not transmitted to the Centers for Medicare and Medicaid Services until 03/17/22.

During an interview on 04/27/22 at 3:39 PM, the MDS Coordinator confirmed Resident #7's completed quarterly MDS assessment dated 01/28/22 was not transmitted within the regulatory time frame. She explained in January 2022, she was out of work for several weeks and there was no one to cover her position. In addition, she

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stated when she returned to work, she was pulled to do other tasks, such as COVID testing and covering the COVID-19 quarantine unit, which put her further behind on completing and transmitting MDS assessments.

During an interview on 04/28/22 at 3:30 PM, the Director of Nursing stated she expected for MDS assessments to be completed and transmitted within the regulatory time frame.

During an interview on 04/29/22 at 12:54 PM, the Administrator stated when she started at the facility in March 2022, she was made aware the MDS Coordinator was behind and some MDS assessments had not been completed or transmitted. The Administrator stated she would expect for MDS assessments to be completed and transmitted within the regulatory timeframes.

4. Resident #8 was admitted to the facility on 01/21/20.

Review of Resident #8's Electronic Medical Record revealed an annual MDS assessment dated 01/31/22 was not transmitted to the Centers for Medicare and Medicaid Services until 03/17/22.

During an interview on 04/27/22 at 3:39 PM, the MDS Coordinator confirmed Resident #8's completed annual MDS assessment dated 01/31/22 was not transmitted within the regulatory time frame. She explained in January 2022, she was out of work for several weeks and there was no one to cover her position. In addition, she stated when she returned to work, she was pulled to do other tasks, such as COVID testing and covering the COVID-19 quarantine unit, which put

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her further behind on completing and transmitting MDS assessments.

During an interview on 04/28/22 at 3:30 PM, the Director of Nursing stated she expected for MDS assessments to be completed and transmitted within the regulatory time frame.

During an interview on 04/29/22 at 12:54 PM, the Administrator stated when she started at the facility in March 2022, she was made aware the MDS Coordinator was behind and some MDS assessments had not been completed or transmitted. The Administrator stated she would expect for MDS assessments to be completed and transmitted within the regulatory timeframes.

5. Resident #9 was admitted to the facility on 09/02/21.

Review of Resident #9's electronic medical record revealed a significant change MDS assessment dated 01/31/22 was not transmitted to the Centers for Medicare and Medicaid Services until 03/17/22.

During an interview on 04/27/22 at 3:39 PM, the MDS Coordinator confirmed Resident #9's completed significant change MDS assessment dated 01/31/22 was not transmitted within the regulatory time frame. She explained in January 2022, she was out of work for several weeks and there was no one to cover her position. In addition, she stated when she returned to work, she was pulled to do other tasks, such as COVID testing and covering the COVID-19 quarantine unit, which put her further behind on completing and transmitting MDS assessments.

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During an interview on 04/28/22 at 3:30 PM, the Director of Nursing stated she expected for MDS assessments to be completed and transmitted within the regulatory time frame.

During an interview on 04/29/22 at 12:54 PM, the Administrator stated when she started at the facility in March 2022, she was made aware the MDS Coordinator was behind and some MDS assessments had not been completed or transmitted. The Administrator stated she would expect for MDS assessments to be completed and transmitted within the regulatory timeframes.

6. Resident #10 was admitted to the facility on 10/18/21.

Review of Resident #10's electronic medical record revealed a quarterly MDS assessment dated 01/25/22 was not transmitted to the Centers for Medicare and Medicaid Services until 03/17/22.

During an interview on 04/27/22 at 3:39 PM, the MDS Coordinator confirmed Resident #10's completed quarterly MDS assessment dated 01/25/22 was not transmitted within the regulatory time frame. She explained in January 2022, she was out of work for several weeks and there was no one to cover her position. In addition, she stated when she returned to work, she was pulled to do other tasks, such as COVID testing and covering the COVID-19 quarantine unit, which put her further behind on completing and transmitting MDS assessments.

During an interview on 04/28/22 at 3:30 PM, the Director of Nursing stated she expected for MDS assessments to be completed and transmitted

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F 640	Continued From page 13 within the regulatory time frame. During an interview on 04/29/22 at 12:54 PM, the Administrator stated when she started at the facility in March 2022, she was made aware the MDS Coordinator was behind and some MDS assessments had not been completed or transmitted. The Administrator stated she would expect for MDS assessments to be completed and transmitted within the regulatory timeframes.	F 640		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its	F 656		5/28/22

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F 656	Continued From page 14 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 observations, record review and staff interviews, the facility: 1) failed to implement interventions by not applying a hand splint as specified in the comprehensive care plan and 2) failed to complete and individualize an activity of daily living care plan for 2 of 3 sampled residents reviewed (Resident #5 and Resident #11). Findings included: 1. Resident #5 was admitted to the facility on 05/07/21 with diagnoses that included cerebral infarction (stroke), osteoarthritis, and hand contracture. Review of Resident #5's electronic medical record revealed the following active physician's orders: 07/19/21 read, apply right hand resting splint to be worn during the PM shift and worn throughout the night as tolerated. Check skin around area of splint prior to application at bedtime for	F 656	1. Resident #5 care plan and Kardex was updated and individualized related to ensuring that the hand splint is applied as ordered on 5/2/22 by Occupational Therapy. Nursing staff was educated by the Staff Development Coordinator / designee related to ensuring Resident #5 hand splint is in place as ordered. Resident #11 no longer lives at the facility. 2.An audit was completed of the current residents with splints by the Regional MDS Coordinator on 4/26/22to ensure that residents with splints have updated and individualized care plans. 3. The licensed nurses will educate by the Staff Development Coordinator/designee related to ensuring splint care plans are updated, individualized and splints are in place as ordered by 5/27/22. The nursing staff to	

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F 656	Continued From page 15 contracture management. 07/20/21 read, remove right resting hand splint in AM. Check skin around area of splint after removal one time a day for contracture management. Resident #5's Activity of Daily Living (ADL) care plan, last revised on 07/25/21, addressed an ADL self-care deficit related to stroke, osteoarthritis, and weakness. Interventions included for staff to apply a right-hand resting splint in the PM, remove in the AM and check skin when applying and removing the splint. The quarterly Minimum Data Set (MDS) dated 01/17/22 assessed Resident #5 with intact cognition. The MDS noted Resident #5 required supervision with eating and extensive to total staff assistance with all other ADL. An observation and interview on 04/26/22 at 5:36 PM, revealed the top part of Resident #5's fingers, on both hands, were bent and curved inward toward the palms with no splint or other device in place. Resident #5 explained staff were supposed to apply a splint to his right hand every night but it hadn't been done. Resident #5 was unable to recall the names of the staff but explained when he asked them about his hand splint, staff told him they did not know where it was. During an interview on 04/29/22 at 9:20 AM, Nurse Aide (NA) #3 revealed she had worked at the facility approximately one month and was routinely assigned to provide Resident #5's care during the hours of 7:00 AM to 7:00 PM. NA #3 voiced she was unaware Resident #5 was supposed to wear a right hand splint during the	F 656	include Certified Nursing Assistance (CNA), Certified Medication Aide (CMA), licensed nurses, new hires and agency nursing staff will be educated by the SDC to ensure the Kardex is also being reviewed. Facility and agency nursing staff will not be allowed to work until education is completed. 4.The Director of Nursing/ designee will audit 5 random residents with splints to ensure care plans or updated and individualized weekly for 4 weeks and monthly for 2 months. The Director of Nursing will report the findings of the audits to the Quality Assurance Process Improvement committee for 3 months for review and recommendations to ensure the facility maintains compliance	

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F 656	Continued From page 16 night and stated she did not recall him ever having one in place when she started her shifts. During an interview on 04/29/22 at 9:25 AM Nurse #3 revealed she had worked at the facility for approximately one year and was routinely assigned to provide Resident #5's care during the hours of 7:00 AM to 7:00 PM. Nurse #3 confirmed Resident #5 had an order for a right hand splint to be applied every evening and removed every AM. Nurse #3 stated on the days she had provided care to Resident #5 she had not observed the hand splint to be in place for her to remove but she had assessed his skin per the physician's order and noted it on his treatment administration record. Telephone attempts on 04/28/22 at 2:00 PM and 04/29/22 at 9:57 AM for an interview with Nurse #4, who was assigned to provide care to Resident #5 during the hours of 7:00 PM to 7:00 AM, were unsuccessful. Telephone attempt on 04/29/22 at 11:24 AM for an interview with NA #4, who was assigned to provide care to Resident #5 during the hours of 7:00 PM to 7:00 AM was unsuccessful. During an interview on 04/29/22 at 10:33 AM, the Director of Nursing stated it was her expectation for the application of hand splints to be completed per physician's order. During an interview on 04/29/22 at 12:54 PM, the Administrator stated it was her expectation for staff to apply Resident #5's hand splint as specified in his comprehensive care plan.	F 656		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility	F 688		5/28/22

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F 688	Continued From page 17 CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to apply a hand splint for contracture management per physician's order for 1 of 1 sampled resident reviewed (Resident #5). Findings included: Resident #5 was admitted to the facility on 05/07/21 with diagnoses that included cerebral infarction (stroke), osteoarthritis, and hand contracture. Review of Resident #5's electronic medical record revealed the following active physician's orders: 07/19/21 read, apply right hand resting splint to	F 688	1.Resident #5 was evaluated by therapy on 5/2/22 to ensure proper fit and application of the splint. 2. Residents with splints have the possibility of being affected by not having their splints donned. Therapy reviewed the current residents with splints by 5/20/22to ensure proper fit and application of the splint. 3.Nursing staff to include agency staff will be educated by 5/27/22 related to ensuring resident splints are in place as ordered by the nursing staff. In addition, nursing staff to include agency staff will be educated on use of the Kardex and where	

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F 688	Continued From page 18 be worn during the PM shift and worn throughout the night as tolerated. Check skin around area of splint prior to application at bedtime for contracture management. 07/20/21 read, remove right resting hand splint in AM. Check skin around area of splint after removal one time a day for contracture management. Resident #5's Activity of Daily Living (ADL) care plan, last revised on 07/25/21, addressed an ADL self-care deficit related to stroke, osteoarthritis, and weakness. Interventions included for staff to apply a right-hand resting splint in the PM, remove in the AM and check skin when applying and removing the splint. The quarterly Minimum Data Set (MDS) dated 01/17/22 assessed Resident #5 with intact cognition. The MDS noted Resident #5 required extensive to total staff assistance with most ADL and had no impairment of the upper extremities for functional range of motion. An observation and interview on 04/26/22 at 5:36 PM, revealed the top part of Resident #5's fingers, on both hands, were bent and curved inward toward the palms with no splint or other device in place. Resident #5 explained staff were supposed to apply a splint to his right hand every night but it hadn't been done. Resident #5 was unable to recall the names of the staff but explained when he asked them about his hand splint, staff told him they did not know where it was. With Resident #5's permission, observations conducted of the nightstand, drawers and closet revealed no presence of a hand splint.	F 688	to find information on splints for a resident. Newly hired nursing staff and/or agency staff will be educated prior working on the floor on the care Kardex and ensuring splints are in place. 4.Director of Therapy/ designee will audit 5 residents to ensure splints are in place as ordered for 4 weeks then monthly for 2 months. The Director of Nursing/ designee will report findings of the audits to the Quality Assurance Process Improvement committee for 3 months for review and recommendation to ensure the facility maintains compliance.	

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Subsequent observations conducted on 04/28/22 at 2:27 PM and 04/29/22 at 1:48 PM revealed no hand splint was observed in Resident #5's room.

During a follow-up interview on 04/29/22 at 1:48 PM, Resident #5 stated the fingers of his right hand were pliable, his contracture had not worsened and he felt the hand splint did help.

During an interview on 04/29/22 at 9:20 AM, Nurse Aide (NA) #3 revealed she had worked at the facility approximately one month and was routinely assigned to provide Resident #5's care during the hours of 7:00 AM to 7:00 PM. NA #3 voiced she was unaware Resident #5 was supposed to wear a right hand splint during the night and stated she did not recall him ever having one in place when she started her shifts.

During an interview on 04/29/22 at 9:25 AM Nurse #3 revealed she had worked at the facility for approximately one year and was routinely assigned to provide Resident #5's care during the hours of 7:00 AM to 7:00 PM. Nurse #3 confirmed Resident #5 had an order for a right hand splint to be applied every evening and removed every AM. Nurse #3 stated on the days she had provided care to Resident #5 she had not observed the hand splint to be in place for her to remove but she had assessed his skin per the physician's order and noted it on his treatment administration record.

Telephone attempts on 04/28/22 at 2:00 PM and 04/29/22 at 9:57 AM for an interview with Nurse #4, who was assigned to provide care to Resident #5 during the hours of 7:00 PM to 7:00 AM, were unsuccessful.

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F 688	Continued From page 20 Telephone attempt on 04/29/22 at 11:24 AM for an interview with NA #4, who was assigned to provide care to Resident #5 during the hours of 7:00 PM to 7:00 AM was unsuccessful. During an interview on 04/29/22 at 9:47 AM, the Rehab Manager (RM) explained he had only been at the facility for a few months and had not yet had the opportunity to evaluate the long-term residents for rehab needs. The RM stated Resident #5 had not been on therapy caseload since 2021. The RM stated he was not that familiar with Resident #5 and explained the use of a hand splint would likely be preventative and would not correct or improve his hand contracture. During an interview on 04/29/22 at 10:27 AM, the Medical Doctor (MD) stated she would expect for staff to apply Resident #5's right hand splint the way it was ordered. During an interview on 04/29/22 at 10:33 AM, the Director of Nursing stated it was her expectation for the application of hand splints to be completed per physician's order.	F 688		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 689		5/18/22

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F 689	Continued From page 21 by: Based on observations, record reviews, staff, Resident, Neurologist, Medical Director and Emergency Medical Service (EMS) Paramedic interviews, the facility failed to train a Transportation Aide (TA) to use the securement system during a facility van transport per manufacturer's instructions which resulted in the Resident becoming dislodged from the wheelchair, striking her head on the permanently affixed row of seats then requiring emergency transport to the local hospital for 1 of 1 resident (Resident #1) reviewed for dialysis. Resident #1 was diagnosed with a left temporal subdural hematoma (a condition due to the bleeding under the membrane of the brain usually caused by surgery or injury) that required surgical removal. The facility further failed to train a newly hired Receptionist on the systems in place to prevent a severely cognitively impaired Resident from leaving the facility unattended for 1 of 5 residents (Resident #2) who wandered. Receptionist #1 did not recognize Resident #2 was a resident and opened the door and let him out and when the door alarm sounded the Receptionist did not know what the alarm meant. Resident #2 walked to a nearby sidewalk and lost his balance and fell hitting his head and sustained lacerations to his nose and forehead and was transferred to the local emergency room and received 6 sutures before returning to the facility. The findings included: 1. The undated manufacturer's instructions utilized by the facility and titled, "Vehicle Anchorages and Accessories for 4-Point Wheelchair Securement Systems," read in part: "Securing Wheelchair: Center wheelchair facing	F 689	Past noncompliance: no plan of correction required.	

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forward in securement zone and apply wheel locks. Attach tie-downs into floor anchorages and ensure they are locked in. Attach the four tie-downs hooks to solid frame members or weldments (near seat level). Ensure tie-downs are fixed at approximately 45 degrees and are within the appropriate angles of 10 inches for the back and 25 inches for the front and locked into place. Tie-downs should never pass through the wheels of the wheelchair and should have a clear path from the floor anchorages to the wheelchair frame. Completely pull out each webbing and attach J-hook to solid frame member. Move wheelchair forward and back to remove webbing slack or manual tension webbing with retractor knobs. Attach retractable combination lap/shoulder belt: attach tongue on end of shoulder belt to buckle stalk closest to the wall. Pull the shoulder belt over occupant's chest and insert tongue into the buckle stalk closest to the aisle. Adjust shoulder belt height so that shoulder belt rests on occupant's shoulder, making sure the shoulder belt does not rub against the occupant's neck."

Resident #1 was admitted to the facility on 10/21/21 with diagnoses of end stage renal disease requiring dialysis three times a week, atrial fibrillation and seizures.

Resident #1's quarterly Minimum Data Set dated 11/18/21 indicated the Resident was cognitively intact and was totally dependent on 2 persons for transfers. Resident #1 required a wheelchair for mobility.

A review of a facility reported incident submitted by Administrator #1 on 02/10/22 indicated, Resident #1 was being transported to dialysis on

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02/09/22 when there was a van accident. The Resident was first sent to the regional hospital and then sent to a more acute hospital related to a subdural hematoma. The Transportation Aide (TA) was experienced in driving the van but also had a gap in service. The TA was not currently driving (the van), and the transportation had been contracted out.

A review of an Emergency Medical Services report dated 02/09/22 revealed the EMS arrived on the scene to find Resident #1 lying in the aisle between two rows of seats. The Resident's head was towards the driver's seat and her legs were wrapped around the last row of seats on the left side. The Resident was lying on her left side with her head on a pillow and complained of left shoulder, bilateral hip and bilateral leg pain. The Resident was assessed to have a hematoma on the left side of her head. The Resident stated she did not believe she was wearing a seatbelt. The report continued to explain that Resident #1 was in a confined spot and difficult to roll over so a cervical collar and pain medication was administered before a pelvic binding apparatus could be applied to the Resident. The Resident was then slid down the aisle to the back of the van and placed onto the stretcher and transported to the local hospital.

An interview was conducted with Emergency Medical Services (EMS) Paramedic #1 on 04/29/22 at 10:10 AM. The Paramedic reported she and her partner arrived on the scene of the incident early morning on 02/09/22 and observed the Administrator removing the wheelchair from the van. The Paramedic stated the local fire department had arrived a few minutes before the EMS arrived and had already removed the

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wheelchair from the hooks and reported the wheelchair was in lock down position when they arrived. The Paramedic explained that Resident #1 had fallen headfirst out of her wheelchair and landed on her left side in the isle between the two rows of seats. She continued to explain that the Resident's head was toward the front of the van and her legs were wrapped around the seat post which caused them concern because they thought her legs might have been fractured. The Paramedic stated Resident #1 had a hematoma on the left side of her head. The Paramedic continued to explain that because of the confined position Resident #1 was lying in, they had to administer pain medication and roll her onto a pelvic apparatus before they could slide her to the back of the van and lift her out of the van and onto the stretcher then transported her to the local hospital. The Paramedic stated that Resident #1 reported several times that she did not believe she was wearing a seatbelt.

A review of Resident #1's discharge summary from the local hospital dated 02/09/22 revealed Resident #1 would be transferred to a more acute hospital due to the need for a higher level of care in neurosurgery for a traumatic left subdural hematoma measuring 13 millimeters in thickness and 6 millimeters rightward midline shift.

A review of Resident #1 discharge summary dated 03/07/22 from the more acute hospital revealed Resident #1 was admitted to the Neuro Intensive Care Unit on 02/09/22 for a traumatic left subdural hematoma which measured 13 millimeters in thickness and 6 millimeters rightward midline shift. Resident #1 required a craniotomy on 02/21/22 for an increasing left subacute and chronic mixed density subdural

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hematoma. The Resident remained on the ventilator for two days because of postoperative respiratory failure and was successfully extubated on 02/22/22.

An interview was conducted with Resident #1 on 04/24/22 at 4:10 PM. The Resident explained that on 02/09/22 while she was being transported to her dialysis appointment the TA turned left onto Main street and she fell forward then to the right out of her wheelchair and hit her head on the post that held up the row of seats in the back of the van. The Resident continued to explain that the TA did not put the seatbelt or the shoulder strap on her that she just strapped the wheelchair down to the floor of the van, but she didn't realize that she didn't have the shoulder strap or seatbelt on until she had fallen. She stated that the TA was fairly new in driving her to dialysis and she had never had an issue with not being strapped down in the wheelchair before that day. The Resident stated that after she fell out of the wheelchair the TA stopped the van and went back to her and called the Administrator who told her to call 911. The Resident stated the TA stayed with her until the EMS came to her. Resident #1 explained that she had a headache (pointing to the left side of her head) but it did not bleed. The Resident continued to explain that the paramedics took her to the hospital. She stated the hospital ran several CT (computerized tomography) scans on her and discovered she had subdural hematoma on the left side of her head. Resident #1 explained that she was transported to another hospital that was more equipped to treat the subdural hematoma and had to have surgery to remove the hematoma and ended up being admitted to the intensive care unit and remained on the ventilator for several days. The Resident

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stated she stayed in the hospital until 03/07/22 when she was discharged back to the facility.

An interview was conducted with the Transportation Aide (TA) on 04/25/22 at 11:15 AM. The TA explained that she was hired on 01/25/22 to be the TA and the extent of her orientation to the position was the previous Administrator (Administrator #1) taking her out to the van and showing her how to make sure the side mirrors were adjusted correctly for her and that the safety buttons had to be in the correct position before the lift to the van could be raised or lowered. The TA continued to explain that the Administrator sat in the front passenger seat next to her and directed her to drive to the common places where she would be transporting the residents more often such as the dialysis center, the hospitals, the doctor's offices and around town in order to get practice driving the van. She stated that when they returned to the facility, she asked the Administrator when she would receive training on the securement system and the Administrator told her that "it will come later". The TA stated that she started to hand the van keys back to the Administrator and he told her to keep them because she was now the van driver and she started that day. The TA stated she could not remember what day that was because she did not write it down but she remembered that later that same day the dialysis center called her and told her that Resident #1 was finished with her dialysis and was ready to be picked up. The TA explained that when she picked Resident #1 up from dialysis she hooked her up to the securement system as best as she could (which she later learned that it wasn't the correct way) and brought the Resident back to the facility without incident. The TA continued to explain that one

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day, she did not remember which day, she was transporting Resident #1 in the van and the Resident started to slide down out of her wheelchair and she had to stop the van and reposition the Resident back into her wheelchair. The TA stated when she got back to the facility, she asked the Administrator again for orientation on the securement system but was told again that they would get to it. The TA explained that on the morning of 02/09/22 she was transporting Resident #1 to dialysis and she drove over a section of road construction that caused the van to bounce. The Resident stated to the TA that she was sliding out of the wheelchair and the TA looked into the rearview mirror and saw that the Resident was sliding out of her wheelchair. The TA then stopped the van on the road and went back to the Resident but by the time the TA got back to the Resident she had already slid out of the wheelchair and onto the floor of the van but the wheelchair remained in upright position. The TA stated she could not remember how the Resident was lying on the van floor, but she did remember that she put her sweater under the Resident's head and called the previous Administrator #1 and reported what had happened. The TA stated the Administrator instructed her to call 911 so that she could report her location to them which she did, and the EMS arrived within a few minutes. The TA reported that on that same day (02/09/22) the van was taken out of service and was eventually taken to a specialty company to be inspected to make sure the van was in good working condition. She stated she received a detailed training on the securement system which included watching a video, taking a written test and she had to return demonstration to the Maintenance Supervisor (MS) and received a certificate of completion on

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02/15/22. She indicated all the training had to be completed before she could resume driving the van for resident transportation. She stated the first transportation she conducted was 02/21/22. The TA expressed that after she received the detailed training on the securement system, she knew that she had not been applying the system correctly when she transported the residents.

A telephone interview was conducted with Administrator #1 on 04/25/22 at 5:15 PM. The Administrator explained that on the morning of 02/09/22 he was notified by the TA that she was transporting Resident #1 to dialysis and the Resident started to slide out wheelchair when she drove over a section of road construction and by the time the TA stopped the van and went back to the Resident, she had slid out of the wheelchair and onto the van floor. The Administrator stated he instructed the TA to call 911 and let them know her location so they could assist, and he would be there as soon as he could get there. The Administrator stated he arrived about the same time as the EMS. The Administrator continued to explain that Resident #1 sustained a subdural hematoma which required surgery to be removed and was hospitalized for about a month. The Administrator explained that on that same day after the incident he along with the Maintenance Supervisor (MS) from a sister facility had the TA demonstrate to them how she strapped Resident #1 into the wheelchair that morning and after her demonstration and it was determined that the TA did not apply the shoulder strap and the seatbelt properly on Resident #1, the TA only applied the shoulder strap. Therefore, the Administrator stated the Root Cause Analysis (RCA) was determined to be user error. The Administrator stated the MS from the sister facility inspected the

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van's securement system and it was determined to be in safe working order on 02/09/22. Just for precaution the Administrator explained the van was taken out of service on 02/09/22 and an outside transportation company was utilized until the facility's van was taken to a special mobility van dealership on 02/14/22 for a full safety inspection where again the securement system was determined to be safe and fully functional. The facility van was placed back in service on 02/14/22. The Administrator was asked about the education the TA received on how to drive the facility van and apply the securement system on residents and the Administrator explained that the TA was hired to drive the van because she had prior experience in transporting residents at another facility. He continued to explain that he had previously watched the securement system video and remembered how to apply the securement system so and he oriented the TA on how to drive the van and how to apply the securement system correctly one day before she made her first transport with a resident. The Administrator explained that he had the TA strap him in a wheelchair in the back of the van as if he was the resident and had the TA drive to the most common places that she would frequently be transporting the residents to such as the dialysis center, doctor's offices and hospitals. He stated he did not have the TA watch the securement system video because he did not have the video at the time and did not know how to access it. The Administrator explained that he did not review the TA's driving record before she was hired for the position. He explained that after the incident the TA asked for more training on how to apply the securement system and it was provided. The Administrator explained that the facility purchased the securement system training

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course and the TA, the MS from the sister facility (who now was the MS at the facility) and himself completed the training on the securement system by watching the video, taking a written test and returned demonstration which they received a certificate of completion. The TA completed the course on 02/15/22 and made her first transport on 02/21/22 and the MS and Administrator completed the course on 02/16/22. The Administrator stated future staff hired to drive the van will be required to complete the securement system course.

On 04/27/22 at 11:20 AM a meeting was held in person with the Transportation Aide (TA), the Director of Nursing (DON) and the previous Administrator (Administrator #1) via telephone. An explanation was given to the parties that there were discrepancies with their account of the type and amount of orientation to the TA position and the utilization of the securement system. The TA repeated her account of the extent of her orientation to the van driving process which was driving the Administrator around town to the frequent places that she would be transporting the residents. The TA was adamant that she was not in-serviced on the securement system until after the incident involving Resident #1 occurred. The TA stated she asked the Administrator several times for in servicing on the securement system but was always told it will come, or it will come later. The Administrator explained that he remembered that he had the TA return demonstration to him on how to properly utilize the securement system and had her drive the van around town to the most frequent places she would be transporting the residents with him as the resident in the wheelchair and strapped down in the back of the van. The Administrator stated

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after that demonstration on him, he felt that the TA was good to go. The Administrator did not recall the TA requesting additional training on the securement system until after the incident with Resident #1. When the Administrator was asked to explain the differences in the accounts given by himself and the TA the Administrator stated he had a lot going on at the facility at the time of the incident and he explained the situation as best as he remembered it.

During an interview with the Director of Nursing (DON) on 04/29/22 at 11:25 AM the DON that she was present in Administrator #1's office one day when the TA stepped into the office and asked the Administrator if she could have training on the securement system in the van and the Administrator told the TA that more training would come later. The DON did not recall the date this conversation occurred.

On 04/25/22 at 1:30 PM an interview was conducted with the Maintenance Supervisor (MS) hired on 02/13/22 who at the time of the van incident on 02/09/22 was the MS at a sister facility. The MS reported that he had over 2.5 years of experience with the securement system in the van having been in charge of the van at his previous employment. The MS explained that he was called to assist the facility on 02/09/22 when the incident happened with Resident #1. The MS continued to explain that the TA, the Administrator and himself met at the van the afternoon of 02/09/22 to conduct a reenactment of how the TA strapped the Resident in the van. The MS explained that as soon as he opened the back door of the van he knew that the procedure had not been conducted properly because the floor anchorages were in the center of the back of the

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van and not on the side behind the driver therefore, the tie-downs were not applied correctly. The MS stated the wheelchair had to be positioned close to the side of the van in order for the shoulder strap to be applied correctly. He continued to explain that he asked the TA to demonstrate how she applied the seatbelt and the TA positioned the seat belt through the side of the wheelchair panel and he knew instantly that it was not the correct way to apply the shoulder or the seat belt. The MS stated he strapped the Administrator in the wheelchair correctly and drove around the parking lot slamming on the van brakes to demonstrate that if the Administrator stayed upright in the wheelchair then the securement system had been applied correctly which he did. The MS continued to explain that the facility took the van out of service and utilized an outside transportation company to transport the residents. On 02/14/22 he took the van to special mobility distribution and had it serviced and checked out to make sure the securement system was working properly, and the van checked out with no problems. He stated the van was back in service as of 02/14/22. The MS explained that the facility purchased the securement system training course and the TA, the Administrator and himself completed the course which involved watching the video, taking the written test and demonstration and received a certificate of completion before they could drive the facility van. The MS stated anyone designated to drive the van and apply the securement system would have to complete the securement system course before they would be allowed to drive the van and transport a resident.

On 04/25/22 at 3:10 PM the Transportation Aide, with the Maintenance Supervisor present, was

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asked to conduct a reenactment of how the TA applied the securement system to Resident #1 on the morning of 02/09/22. The TA explained that the anchorages and tie-downs were in the center of the van at the time of the incident which meant she had to stretch the shoulder strap too far over to the Resident which prevented her from securing the shoulder strap correctly to the seatbelt and to the Resident. The TA then demonstrated that she had been putting the seatbelt straps through the side panels of the wheelchair instead of putting them straight behind the residents then hooking them to the tie-downs. The TA demonstrated that she had been securing the J-hooks to the outside of the wheelchair frames instead of the insides of the wheelchair frames. The MS then had the TA demonstrate how to apply the securement system according to the manufacturer's instructions.

During an interview with the Neurologist on 04/26/22 at 8:55 AM the Neurologist explained that Resident #1 sustained a left temporal subdural hematoma when she fell from her wheelchair during a transportation. The Neurologist stated the Resident did not have to hit her head hard on the surface to cause the subdural hematoma because everybody reacts differently to the impact. He continued to explain that at first, they thought the hematoma would subside but the CT scans showed that the hematoma was growing and she was transferred to a more acute hospital for placement in the Neuro Intensive Care Unit where he managed her condition. The Neurologist explained that Resident #1 underwent a craniotomy to evacuate the subdural hematoma and progressed to discharge back to the nursing facility. He stated he had seen her once in his office since her

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discharge to remove the sutures and the Resident was doing well from the craniotomy.

An interview was conducted with the Medical Director (MD) on 04/27/22 at 3:00 PM. The MD indicated that Resident #1 was hospitalized for approximately a month for a subdural hematoma related to a van incident during transportation to a dialysis session. The MD explained that the Resident was first assessed at a local hospital but was sent to the more acute hospital because of the need for the Neurosurgery unit. The MD stated Resident #1 underwent a craniotomy to remove the subdural hematoma and because of her lungs being in poor condition she remained on the ventilator for a couple of days before she could be successfully weaned from the ventilator.

The facility provided the following Corrective Action Plan with a completion date of 02/16/22.

The plan of correcting the specific deficiency

* The deficient practice of failing to prevent an accident occurred when the facility failed to ensure proper securement of the wheelchair occupant in the facility van.

* On 02/09/22 while Resident #1 was being transported to dialysis from the facility via the facility van, the van driver over a metal construction plate in the road, causing the van to bounce. The resident alerted the van driver that she was sliding out of the wheelchair and the van driver responded by quickly stopping the van to assist the resident. The resident had already slid out of the wheelchair before the van driver was able to stop. The wheelchair straps were noted to be secured on all four corners of the wheelchair,

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however the shoulder and lap restraint failed to keep the resident in the wheelchair.

* The van driver immediately called 911 and the facility Administrator. The Administrator arrived at the scene of the incident as emergency medical services (EMS) arrived. The resident was assessed by the emergency medical staff, transported from the scene via EMS and was evaluated by a physician in the emergency room. The resident was admitted to the hospital on 02/09/22.

* The investigation of the incident was initiated on 02/09/22 by the Administrator. As a result of a re-enactment of the incident and the van inspection by the Maintenance Supervisor, the facility determined that the incident was related to securement equipment being improperly placed on the resident. A root cause analysis was performed, and it was determined the van driver had been inadequately trained and required additional education. As a result of the incident and of the root cause analysis the following actions were immediately taken:

* The facility van was immediately taken out of service after the incident on 02/09/22.

* A vendor took over the transport duties for the facility during the investigation. Administrator observed a patient being loaded and properly secured on the vendor's van on 02/10/22. The driver confirmed he had viewed a video on proper securement of wheelchair passengers using the Q-Straint system prior to the transport. Owner reported that all drivers are required to view securement video and perform return demonstration of securement knowledge prior to

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transporting any wheelchair occupants. Administrator requested that the vendor submit training documentation for operators/drivers from the company owner.

* The facility van's entire wheelchair securement system was inspected by the Maintenance Supervisor from a sister facility on 02/09/22. It was determined to be safe.

* The facility van was taken to a specialty mobility van dealership, special mobility van dealership on 02/14/22 for a full safety inspection. The securement system was determined to be safe and fully functional.

* The Medical Director and the family of Resident #1 were notified of the incident on 02/09/22.

* On 02/09/22 education was provided to Administrator #1 and the TA by the Maintenance Supervisor from a sister facility. The Maintenance Supervisor will also be responsible to provide education to other designated team members who may operate the facility van to ensure authorized operators have complete knowledge and ability to operate the wheelchair securement system with a return demonstration, and that each is familiar with the facility transport vehicle policy. Staff will not be allowed to drive the van or transport residents until the facility van training is completed and the van is determined to be safe to operate. Newly hired transportation drivers and maintenance staff will also be required to complete training in orientation.

* The van was placed back in service on 02/14/22. The Van Driver had the first appointment with the van on 02/21/22.

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2. Implementing the plan of correction will be completed through the following actions:

* On 02/09/22 the Administrator reeducated the Maintenance Supervisor from the sister facility and the transport driver on the proper application/alignment of the Q-Straint Wheelchair Securement System using the manufacturer's training video, the manufacture's Operator's Manual, and the Facility Transport Vehicle Policy education tools. The Administrator and the transport driver demonstrated competency in using the system to properly secure a wheelchair passenger for transport in the facility van.

* The Van Driver completed the Q'Straint video education on 02/15/22.

* The Maintenance Supervisor will utilize the transport safety education from the Operator's manual, the manufacturer's training video, and the facility transport Vehicle Policy to educate current and future van drivers. The education will include a return demonstration/competency. Van drivers will not be allowed to drive the facility van until the education is completed.

3. Monitoring the plan of Correction for Compliance with Safety Standards and the policy and procedures for preventing accidents will include the following:

* Weekly random boarding/un-boarding observation audits will be conducted by the Maintenance Supervisor/designee who has been trained in the Wheelchair Securement System.

* Audits will be presented to the Quality

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Assurance Performance Improvement (QAPI) Committee Assurance Performance Improvement (QAPI) Committee during monthly meetings for at least 3 months. The plan will be reviewed and revised as needed to maintain compliance.

4. The Administrator will be accountable for ensuring the implementation of this plan of correction.

* The Van Driver education was completed on 02/15/22.

* The van was available for appointments on 02/16/22.

* Currently the Van Driver and the Maintenance Supervisor are the only staff members allowed to drive the van.

* All immediate actions have been completed or started within the timeline of the Plan of Compliance.

The alleges compliance as of 02/16/22.

The Corrective Action Plan was validated on 04/29/22 and concluded the facility implemented an acceptable corrective action plan on 02/16/22. The facility provided training to the Transportation Aide, Administrator #1 and the Maintenance Supervisor on the specific securement system utilized in van transportations which was evident by a certificate of completion. The facility van was taken out of service on 02/09/22 and an outside transportation company was utilized until 02/14/22 and the first transportation with the facility van was 02/21/22 which was verified by van logs. The facility van was taken to a special

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mobility distribution service and the securement system was inspected and was determined to be in good working order on 02/14/22. The Maintenance Supervisor will be the person in charge of orientation of the securement system anyone hired to drive the van and transport the residents.

The weekly random boarding and unboarding observation audits were reviewed for accuracy and completion. The audits were presented in the monthly (March/April) Quality Assurance Performance Improvement (QAPI) Committee during monthly meeting by the Administrator with no revisions necessary.
2. Resident #2 was admitted to the facility on 02/03/22 with diagnoses that included unsteadiness on feet, lack of coordination, difficulty in walking, and repeated falls.

Review of a wandering assessment dated 02/04/22 indicated Resident #2 was low risk for wandering.

The quarterly Minimum Data Set (MDS) dated 03/14/22 revealed that Resident #2 was severely cognitively impaired and required limited assistance with walking in the room and in the corridor. The MDS further revealed that Resident #2 had no behaviors, rejection of care or wandering.

Review of an incident report dated 04/22/22 at 4:15 PM by Nurse # 2 read in part, Resident #2 was let out of facility by the staff member assigned to the front desk (Receptionist #1) who didn't realize that he was a resident and had a wanderguard (used to keep wandering resident from exiting facility unattended) in place. The

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door alarm was sounding when Resident #2 exited the building and began to run across the parking lot as staff was attempting to redirect him back to the facility. Resident #2 lost his balance and fell on the pavement. Staff assisted Resident #2 up and he was able to ambulate back into facility without difficulty. He was noted to have a laceration to his mid nose/ forehead. The Medical Doctor (MD) was notified, and an order was given to send Resident #2 to the Emergency Room (ER) for evaluation.

Review of Receptionist #1's personnel file revealed that she was hired by the facility on 04/17/22. The file revealed no education was given to Receptionist #1 upon hire on the facility's wanderguard system or the door alarms that were present in the facility or what the alarms meant or what to do if the alarm sounded.

Receptionist #1 was interviewed on 04/26/22 at 4:39 PM and confirmed that she had worked at the facility for approximately one week and was working the front desk on 04/22/22. She stated that at approximately 4:15 PM a gentleman (who she did not know) approached the door dressed in "normal clothes and shoes." Receptionist #1 stated she got up from behind the desk and went to the door and entered the door code and opened the door and the gentleman exited the facility. She stated that when he walked out the door the alarm began to sound but she "was not sure what it was." A moment later a nurse that she did not know come to the front desk and asked why the alarm was sounding and was told that it went off when that gentleman walked out. Receptionist #1 stated that the nurse looked out the window and took off running after the gentleman who she later learned was Resident

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#2. She stated she stayed at the door so she could let the nurse and Resident #2 back into the facility when they got back to the door. Receptionist #1 stated that she was hired as the receptionist to work the front desk but was never trained or given any information on the door or alarm systems, what they meant, or what to do if the alarm sounded. Receptionist #1 stated that later that evening on 04/22/22 the Administrator had given her education on the doors, door alarms, what they meant, and how to respond to the alarm. Then on 04/23/22 another nurse manager who she did not know, again educated her on the same doors, door alarms, what they meant, and how to respond to the alarms.

Nurse #1 was interviewed on 04/26/22 at 2:57 PM and confirmed that she was working on 04/22/22 and at approximately 4:15 PM she was on a medication pass. One of the residents stated that they had food at the front desk and asked her wanted me to go and get it. Nurse #1 stated that as she approached the front lobby area, she heard the door alarm sounding and asked Receptionist #1 why was the door alarm sounding and she replied, "I don't know but it started when that guy went out." Nurse #1 asked Receptionist #1 what guy, what did he look like? Nurse #1 stated that she looked out the front door and saw Resident #2 walking very fast up the hill on the sidewalk that ran alongside the main road. Nurse #1 stated she immediately ran out after Resident #2 who had on a t-shirt, pajamas bottoms, and shoes. As Resident #2 was making his way towards the road he fell on the paved sidewalk and was trying to get up. Nurse #1 stated she hollered back for Receptionist #1 to get her some help and asked Resident #2 to wait for her and she would help him up, but Resident #2

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continued to get up on his knees and was on his feet when she reached him. He was bleeding from his face area but did not appear to be injured anywhere else. She stated that she and Nurse Aide (NA) #1 walked with Resident #2 back into the facility so they could get his face cleaned up and assess his injuries. Nurse #1 stated that Resident #2 was very cooperative and appreciative of the help and had no issues coming back inside the facility. Once Resident #2 was back into his room she and Nurse #3 cleaned up his face and discovered the laceration to his nose/forehead and applied a pressure dressing while Nurse #2 contacted the MD who gave an order to send Resident #2 to the ER. Nurse #1 nurse stated that Emergency Medical Services (EMS) arrived quickly to transport Resident #2 to the ER. She stated that they had to cut his wandergurad off his ankle prior to exiting the facility. Nurse #1 stated that Resident #2 had not returned to the facility by the time she left after her shift.

Nurse #3 was interviewed on 04/26/22 at 3:35 PM and confirmed that she worked on 04/22/22. Nurse #3 stated that approximately 4:15 PM she was on her unit and heard the door alarm sound. She stated she and the rest of the staff began looking for where the alarm was coming from. She stated she went down her hallway and everyone was accounted for, and her alarm was not sounding, and she proceeded to the front and was met by Nurse #1 and NA #1 with Resident #2. Nurse #3 stated she assisted Nurse #1 with Resident #2 who was bleeding from his face area. She stated that began cleaning the area and discovered a laceration to his nose/forehead and they applied a pressure dressing. Nurse #3 stated that Resident #2 was not complaining of

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any pain or discomfort and was very cooperative with the staff. She added that Nurse #2 had contacted the MD and gotten an order to send Resident #2 to the ER and within minutes EMS arrived and took Resident #2 to the ER.

Attempts to speak to NA #1 were made on 04/26/22, 04/27/22, 04/28/22, and 04/29/22 were unsuccessful.

Review of ER records dated 04/22/22 indicated that Resident #2 present to the local ER after a fall on concrete from an upright position. The physical exam revealed a mild abrasion to the nose and a jagged laceration to the forehead. No signs of basilar skull fracture. The wound repair included 5 sutures to the forehead and 1 to the bridge of nose. The records indicated that Resident #2 was stable for discharge back to the facility at approximately 10:30 PM on 04/22/22.

The Business Office Manager (BOM) was interviewed on 04/27/22 at 9:29 AM. The BOM confirmed that she had trained Receptionist #1 upon her hire. She stated that the Receptionist position was not a part of the nursing department so wandergurad training was not included in her training portion of Receptionist #1 orientation. She did confirm that she had since added that information into her orientation packet to do with future hired Receptionist or non-nursing employees.

The Administrator was interviewed on 04/27/22 at 9:03 AM. The Administrator stated that on 04/22/22 she received a call from Nurse #2 at approximately 4:45 PM telling her about Resident #2 getting outside in the parking lot. The Administrator stated she told Nurse #2 that she

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was on her way back to the facility because the Director of Nursing (DON) was out of town. The Administrator stated when she arrived back at the facility at approximately 5:00 PM Resident #2 had already left the facility to go to the ER, so she ensured the alarms were functioning properly and had the Maintenance Director check all the door and alarms as well and they were all working as they should. She added that they completed a head count to ensure all residents were accounted for and began the investigation. The Administrator stated that when she started to interview the staff, she quickly learned that Receptionist #1 had no idea why the alarm was sounding or what to do when she heard the alarm. She immediately provided a one-to-one education on the wandergurad system, the door alarms, what they meant, and how to respond if the alarm went off. The Administrator also oriented Receptionist #1 to the wandering book at the front desk that had the pictures of all wandering resident in it that she could refer to if she was unsure if the person wanting out of the door was a resident or not. She added that the BOM completed Receptionist #1 training, but the wandergurad system and door alarms were not included in her education for some reason. The Administrator stated that she had since added that information into the general orientation handbook as well agency orientation handbook so that all staff were aware of the systems in place to keep wandering residents from exiting the facility unattended. She agreed that the information on wandergurad system and door alarms should have been included in Receptionist #1 training and could not speak to why it was not as she had only been at the facility for a month.

An observation of the facility parking lot was

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made on 04/27/22 at 9:30 AM with the Administrator. The area that Resident #2 was found was approximately 150 feet from the front door of the facility on a sidewalk that was approximately 5 feet from a main road that had a posted speed limit sign of 35 miles per hour.

An observation and interview were conducted with Resident #2 on 04/29/22 at 1:05 PM. Resident #2 was resting in bed with his eyes open. He was noted to have a laceration to his mid forehead and bridge of nose that both had sutures in them. Resident #2 recalled going outside and stated, "I got dizzy and fell and hit my head." He stated he did not get any "stitches" that he could remember. Resident #2 stated he walked to the door, and no one told him he could not go outside so he just walked out but could not recall if someone opened the door for him or not. Resident #2 stated that the staff sat with him all the time now.

The Maintenance Director was interviewed on 04/27/22 at 10:07 AM and confirmed that he was in the facility on 04/22/22 when the Administrator called him and asked him to check the wandergurad system and door alarm to ensure they were working correctly. He stated that he went to each door and made sure the door was locked and that the wandergurad system was working if that door had the system attached to it and all were working correctly. The Maintenance Director also stated that he took the wanderguard that Resident #2 had on and ensured it was working correctly and it was.

The MD was interviewed on 04/27/22 at 11:45 AM and stated that she had been made aware that Resident #2 had gotten out of the facility had

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fallen and went to the ER. She stated that Resident #2 had no history of wandering that she was aware and when she would visit, she would notice staff would be with him due to his history of frequent falls. Due to his frequent falls Resident #1 should have not been outside without family or staff available to assist him. The MD stated that Resident #2's mental status would never improve but physically he was pretty stable.

The facility provided the following Corrective Action plan with a completion date of 04/24/22:

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

On 04/22/22 at approximately 4:20 PM Resident #2 was observed on the sidewalk by the parking lot by Licensed Nurse (LN) #1. Based upon LN #1 interview, she heard the alarm for the front lobby door from the 200 hall and ran to it. When she got to the lobby, she observed Receptionist #1 at the door and Resident #2 in the parking lot. She went to bring him back inside the facility. At that point, he turned and lost his balance on the sidewalk and fell forward. Resident #2 obtained a cut to his forehead. LN #1 along with a Nurse Aide (NA) assisted the resident back into the facility without difficulty. The resident was attempting to stand on up on his own before an assessment for the fall could be completed. LN #1 ascertained it would be safer for the resident to assist him as opposed to try and keep in a lying position. The resident was in his room when EMS arrived to take him to the ER for evaluation and treatment. The resident verbally responded to the staff appropriately. An assessment was completed, and incident report completed in the electronic health record.

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Based upon interviews with staff, the resident remained in line of vision until returned to the facility. The newly hired Receptionist did not understand why the alarm was going off and thought that Resident #2 was a visitor when she opened the door. When the door opened the alarm sounded and LN#1 responded. The DON and NHA were notified at approximately 4:52 PM.

An investigation began by the Administrator on 04/22/22. One to one observation was initiated on 04/22/22 upon Resident #2's return from the ER and will be maintained. Wander Risk Assessment completed, care plan initiated, family and physician were notified.

All residents who are cognitively impaired and exhibit exit seeking and wandering behaviors are at risk of exiting the facility. These residents were identified by reviewing current residents most recent wandering risk assessment and identifying those residents who were assessed as high risk for elopement. The following plan has been formulated to address the issue:

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or reoccurring and when the action will be complete:

On 04/22/22 the Maintenance Director checked all the exit doors to ensure they were locked, and the wandergurad system was active.

An elopement drill and education were completed on 04/22/22 by the Administrator. The elopement drill and education were repeated for the evening shift on 04/22/22 by the Administrator. Elopement

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Drill and education will continue daily through the weekend and be re-evaluated by an ad hoc QAPI meeting on Monday for further needs.

On 04/22/22 a facility head count was completed to ensure all resident were in the facility. The Maintenance Director ensured the alarms were functioning at the doors.

Beginning 04/23/22 the Assistant Director of Nursing (ADON) completed elopement education and drills with all current facility and agency staff, including nursing, dietary, maintenance, housekeeping, therapy, and administrative staff. Education included a review of the facility elopement policy. As well as education emphasized the need to ensure effective supervision for cognitively impaired resident with wandering and exit seeking behaviors to prevent unsupervised exits from the facility. Residents care plan should be reviewed to determine resident specific interventions when wandering and/or exit seek behaviors are identified. Any newly identified residents who exhibit exit seeking behaviors should be immediately assessed by the nurse and an intervention implemented to mitigate any elopement attempts. All staff were educated on where the elopement binders were located. Elopement binders are located at each nursing station and at the front desk. Any door malfunctions should be communicated to the maintenance director or Administrator immediately. Nursing staff assignment for any resident who requires one to one will be noted on the staff assignment sheet. Staff were informed to review the assignment sheet to determine if they were assigned to provide one on one supervision. The Administrator will utilize a master employee list to track completion of education. Education

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will also be included during orientation for newly hired staff.

On 04/22/22 the Administrator ensured the Elopement Risk binder at the receptionist desk was accurate. On 04/23/22 the ADON ensured the Elopement Risk binder to contain resident profiles and photographs were at each nurse's station.

Effective 04/23/22, licensed nurses were educated by the ADON on ensuring resident wandering assessment were completed accurately upon admission, quarterly, and with changes in resident condition. Any assigned wandering assessment will display (based upon date the assessment should be completed) in the user defined assessment portal in the facility's electronic medical record. Nurses were educated to review the user define assessment portal at the start of the shift to determine any wandering assessments due on their assigned shift for their assigned residents. An emphasis was placed on ensuring wandering assessment are thoroughly completed which included contacting the resident's family to discuss past behavioral issues such as wandering/exit seeking behaviors as well as a review of the hospital records to determine if there is any history of exit seeking behaviors. Unit Coordinator will monitor the user defined assessment portal daily during clinical meeting to ensure wandering assessment are completed as scheduled.

Effective 04/22/22 all residents will be assessed for elopement by a nurse upon admission, quarterly, and with changes in resident condition.

Effective 04/22/22 resident identified at risk with

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exit seeking and wandering behaviors will have a care plan in place to ensure safety and profile photo, wandering risk assessment, and care plan will be placed in the elopement binder at the nurse's station and front desk. Residents with wandergurads will be monitored every shift for placement and every day for function by the nurse.

Effective 04/22/22 staff assigned to provide one on one resident supervision will not leave resident unattended at any time. During staff breaks and during change of shift, an alternative staff member will provide supervision.

Effective 04/22/22 the facility will conduct an elopement drill on all shifts monthly to ensure continued staff understanding of the facility process in the event of an elopement.

Effective 04/22/22 newly hired Receptionist received education by the Administrator regarding elopement education, elopement risk binder, the reason for the door alarm system, door security system, and process for system malfunction (as applicable). Education to include elopement policy and procedure, wandergurad system and door alarm safety checks weekly.

Effective 04/22/22 the facility will ensure proper functioning and monitoring of the wandergurad system and facility door alarm system. The Maintenance Director, Maintenance Assistant, or Administrator will perform and document door and alarm safety checks at least weekly. This will be documented in the electronic system used for maintenance tracking.

Effective 04/22/22 the facility will include the

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elopement policy and procedure with general orientation (all nursing and ancillary staff attend this) and to the agency orientation. Staff will not work until educated on the process.

Effective 04/23/22 the Administrator or Regional Director of Operations and Director of Nursing will be ultimately responsible to ensure implementation of this immediate jeopardy removal for this alleged noncompliance.

Alleged date of IJ removal: 04/24/22.

The Corrective Action Plan was validated on 04/28/22 and 04/29/22 and concluded the facility had implemented an acceptable corrective action plan on 04/24/22. The facility provided education and training on the facility's elopement policy and procedures, placed elopement binders at each nurse's station and the front desk, ensured all components of the wandergurad system and door alarms were functioning and ensured staff knew how to respond to an elopement and door alarms. In addition, all residents who were at high risk for wandering were identified using the wandering risk assessment and ensured all had a care plan with interventions in place to mitigate an elopement.

The monitoring tools were reviewed for 04/22/22, 04/23/22, and 04/24/22 for all door inspections including the doors equipped with the wandergurad system. Staff interviews along with education sign in sheets revealed that all staff had been trained and were aware where the elopement binders were located, how and when to complete wandering risk assessments, and how to respond to a door alarm. A door alarm was sounded with staff responding appropriately

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F 689	Continued From page 52 within 57 seconds. The corrective action plan was reviewed in an ad hoc QAPI meeting on 04/25/22.	F 689		
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, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff and Physician interviews, the facility failed to administer oxygen as prescribed by the Physician for 1 of 2 residents (Resident #3) reviewed for oxygen therapy. The finding included: Resident #3 was admitted to the facility on 04/22/13 with diagnoses that included chronic obstructive pulmonary disease and heart failure. Resident #3's care plan revised on 07/20/21 indicated the Resident received oxygen therapy related to chronic obstructive pulmonary disease. The goal for Resident #3 to display optimal breathing patterns would be attained by utilizing interventions that included administering oxygen via nasal cannula at the rate ordered by the Physician. The quarterly Minimum Data Set (MDS)	F 695	1.Resident #3 oxygen orders were reviewed by the Director of Nursing on 4/29/22 to ensure resident is receiving oxygen as ordered by the physician. 2.Current residents oxygen orders were reviewed by the Director of Nursing to ensure residents are receiving oxygen as ordered on 5/18/22 3.The licensed nurses will be educated by the Assistant Director of Nursing (ADON)/ designee by 5/27/22 related to ensuring residents are receiving oxygen as ordered and being checked minimally each shift and as needed. New Licensed staff member and agency will received education prior to working on the floor. 4.Director of Nursing/ designee will audit 5 residents weekly for 4 weeks and monthly for 2 months to ensure residents continue to receive oxygen as ordered. The Director of Nursing/ designee will report findings of the audits to the Quality	5/28/22

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assessment dated 12/31/21 revealed Resident #3 had moderately impaired cognition and required extensive assistance for most of her activities of daily living. The MDS also indicated the Resident required oxygen therapy.

A review of Resident #3's medical record revealed an ordered dated 02/22/22 for oxygen to be continuously administered at 2 liters per minute via nasal cannula.

An observation was made on Resident #3 on 04/28/22 at 10:45 AM. Resident was lying in bed with the head of the bed at an approximate 30-degree angle. The Resident received oxygen via nasal cannula delivered at 3 liters per minute by an oxygen concentrator which was positioned on the floor on the right side of the bed behind Resident #1's head. The Resident's respirations were even and unlabored at 19 respirations per minute.

A second observation made of Resident #3 on 04/28/22 at 2:55 PM revealed the Resident was lying in bed with the head of the bed elevated approximately 30 degrees. The oxygen setting was at 3 liters per minute via the nasal cannula. No acute respiratory distress was noted.

On 04/28/22 at 3:00 PM an interview was conducted with Nurse #2. The Nurse explained that she assessed Resident #3 during her morning medication pass and explained that she noted that her vital signs were within normal limits and her oxygen saturation was 96%. The Nurse continued to explain that she checked the Resident's oxygen setting every time she went into her room and the setting was between 2-3 liters per minute. Surveyor requested the Nurse

Assurance Process Improvement committee for 3 months for review and recommendations to ensure the facility continued compliance.

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F 695	Continued From page 54 to review the Physician's order for the correct oxygen setting and the Nurse looked at the order and stated the Physician's order for the Resident's oxygen setting should be on 2 liters per minute. On 04/28/22 at 3:05 PM Nurse #2 was asked to accompany the Surveyor to Resident #3's room where the Nurse observed the Resident's oxygen setting was on 3 liters per minute. The Nurse stated she thought it was set at between 2-3 liters and adjusted the oxygen setting to 2 liters per minute. An interview was conducted with the Director of Nursing on 04/29/22 at 9:25 AM who expressed that her expectation was that the oxygen should be administered as the Physician ordered. On 04/29/22 at 10:20 AM during an interview with the Physician she explained that her expectation was for Resident #3's oxygen be administered at 2 liters per minute unless the Resident was experiencing an acute respiratory episode then she would expect the Nurse to titrate the oxygen for low oxygen saturations. An interview was conducted with the Administrator on 04/29/22 at 12:55 PM. The Administrator expressed that she expected the residents' oxygen settings be delivered at the prescribed rate given by the Physician.	F 695		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 761		5/28/22

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F 761	Continued From page 55 professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility failed to remove expired medication from 1 of 2 medication carts (300 hall) observed during medication pass and failed to remove expired medication from 2 of 4 medication carts (100 hall and 200 hall) reviewed during medication storage. The findings included: 1. An observation of a medication pass was conducted on 04/26/22 at 9:15 AM with Medication Aide (MA) #1. MA #1 was observed to prepare Resident #13's medications that included Aspirin 81 milligrams (mg) that had an expiration	F 761	1.The expired medications were removed from the medication carts on 100, 200, and 300 halls by the Director of Nursing on 4/29/22 and discarded. 2.The facility medication carts were checked for expired medications by Director of Nursing/ designee on 5/19/22 and any identified expired medications were discarded. 3.The facility licensed nurses to include agency licensed nurses will be educated on the Medication Storage Policy by the Assistant Director of nursing/ designee by 5/27/22. New hire licensed nurses and agency licensed nurses will not be allowed	

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F 761	Continued From page 56 date of 02/22 on the bottle. Once MA #1 had prepared all of Resident #13's medication she locked the medication cart and entered the resident's room to administer the medication. Just prior to the administration MA #1 was prompted to check the Aspirin bottle's expiration date. MA #1 confirmed the Aspirin expired on 02/22, she donned a glove and removed the expired Aspirin from the medication cup and obtained another Aspirin 81 mg that was not expired placed it in the medication cup and again entered the resident room to administer the medication. MA #1 was interviewed on 04/26/22 at 9:20 AM. MA #1 stated, "I am sure night shift was responsible for going through the medication carts." She stated that she arrived for her shift this morning and got report and started her medication pass. MA #1 stated she tried to check the medications as she went to ensure none were expired and reorder medications as needed but stated she had not checked the expiration date on the Aspirin bottle prior to entering Resident #13's room to administer her medications. The Assistant Director of Nursing (ADON) was interviewed on 04/29/22 at 11:23 AM who stated that the hall nurses were to check their medication carts daily for expired medications and pull them but "with all the agency staff it is very difficult to get them to do anything." The ADON stated that the pharmacy came sporadically but not routinely and helped go through the medication carts. The ADON added that all expired medication should be removed from the medication carts and returned to the pharmacy. The Director of Nursing (DON) was interviewed	F 761	to work prior to receiving the education. 4.The Director of Nursing/ designee will complete audits of the medication carts weekly for 4 weeks and monthly for 2 months to ensure expired medications continue to be removed and discarded from the medication carts. The Director of Nursing will report her findings to the monthly Quality Assurance Improvement Committee for 3 months for review and recommendations to ensure the facility continued compliance	

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on 04/30/22 at 11:30 AM. The DON stated that the hall staff should be looking at each medication they administer to ensure that they were not expired. She stated that the facility periodically did cart audits but realistically those were not getting done because they were relying on the hall staff to check them daily. The DON added that the pharmacy was in the facility on 04/25/22 to perform medication cart audits and all expired medication should have been removed from the medication carts.

2a. An observation of the 200-hall medication cart was conducted on 04/28/22 at 11:51 AM along with Nurse #2. The observation revealed the following expired medications that were on the medication cart and available for use:

Nephro vitamins 1 opened bottle that expired on 01/22.
Clonidine (treat blood pressure) 0.1 mg 28 tablets that expired on 04/09/22.
Benzonatate (antitussive) 100 mg 26 tablets that expired on 02/15/22.

Nurse #2 was interviewed on 04/28/22 at 12:13 PM. Nurse #2 stated she was not sure who was responsible for checking the medication cart for expired medication but added "she had not given those medications." Nurse #2 stated that she "tried to go through the medication cart" each day she worked but she did not always have the time. Nurse #2 also stated that she had been told the pharmacy had recently been at the facility and she assumed they had removed all the expired medications from the medication cart.

2b. An observation of the 100-hall medication cart was conducted on 04/28/22 at 2:23 PM with

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Nurse #3. The observation revealed the following expired medications that were on the medication cart and available for use:

Ondansetron (antiemetic) 4 milligrams (mg) 20 tablets that expired 01/13/22.
Ondansetron 4 mg 6 tablets that expired 01/29/22.
Lomotil (treat diarrhea) 2.5 mg 36 tablets that expired 02/26/22.

Nurse #3 was interviewed on 04/28/22 at 2:35 PM. Nurse #3 stated that the hall nurses were expected to go through the medication carts and remove any expired medication as they have the time. Nurse #3 stated that she had recently relieved another staff member that had to leave work early and stated she had "skimmed through" the cart but had not seen the expired medication. Nurse #3 stated that she would take the expired medication and give it to the Assistant Director of Nursing (ADON) so it could be returned to the pharmacy.

The ADON was interviewed on 04/29/22 at 11:23 AM who stated that the hall nurses were to check their medication carts daily for expired medications and pull them but "with all the agency staff it is very difficult to get them to do anything." The ADON stated that the pharmacy came sporadically but not routinely and helped go through the medication carts. The ADON added that all expired medication should be removed from the medication carts and returned to the pharmacy.

The Director of Nursing (DON) was interviewed on 04/30/22 at 11:30 AM. The DON stated that the hall staff should be looking at each

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F 761	Continued From page 59 medication they administer to ensure that they were not expired. She stated that the facility periodically did cart audits but realistically those were not getting done because they were relying on the hall staff to check them daily. The DON added that the pharmacy was in the facility on 04/25/22 to perform medication cart audits and all expired medication should have been removed from the medication carts.	F 761		
F 802 SS=E	Sufficient Dietary Support Personnel CFR(s): 483.60(a)(3)(b) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is not met as evidenced by: Based on observations, record review, and facility staff and resident interviews, the facility failed to have sufficient dietary staff to ensure the menu was followed. On 04/24/22 a dietary aide was the only staff member that reported to work	F 802	1. identified dietary aide on 4/24/22 was educated by the Regional Dietary Manager on 5/19/22 related to making sure that the Dietary Manager is notified of staffing concerns and menus are not	5/28/22

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F 802	Continued From page 60 and made the decision without consultation from the Dietary Manager or Regional Dietary Manager to serve residents sandwiches for the evening meal. This affected all residents with diet orders. The findings included: An observation of the facility's kitchen was completed on 04/25/22 at 10:22AM revealed 3 staff members in the kitchen. There were two staff members cleaning and 1 running the dishwasher. During an interview with Dietary Aide #1 on 04/28/22 at 12:25 PM, she stated it was routine for there to be only 1 staff member staffed in the kitchen for the dinner meal service, especially on the weekend. During an interview with Dietary Aide #2 on 04/28/22 at 12:53 PM, she reported the kitchen had been short staffed for a while. She stated she had spoken with the Dietary Manager several times about the lack of staff and reported she did not know what, if anything, the Dietary Manager had done to try and hire and schedule more staff. Dietary Aide #2 reported she mainly worked in the mornings but would work some evenings when another dietary aide was off. She also reported she worked the occasional weekend. Dietary Aide #2 reported there had been several times when she was the only staff member in the kitchen for the evening meal and stated "When that happens, you have to prep it, cook it, plate it, serve it, do tea and water. It's a lot." She stated when she was the only staff member in the kitchen, meals do not come out on time and are very late getting to the residents.	F 802	changed without the Dietary Manager□s approval. 2. All residents have the potential to have diet orders be affected by this. All residents have the potential to be affected by changes to the menus. 3. The Regional Dietary Manager educated the facility dietary Manager on ensuring the kitchen is adequately staff and menus are not changed without approval on 5/19/22. The Facility Dietary Manager provided education on 5/19/22 to the dietary staff relating to making sure that the Dietary Manager is notified of dietary staffing concerns and menus are not changed without the dietary managers approval. Newly hired staff and agency staff will be educated prior to working in the kitchen 4. The Culinary Services Manager will audit the weekly schedules to ensure the are a cook and 2 other staff members in the kitchen for meals. This audit will be completed weekly and presented to the QAPI committee for review and recommendation The Dietary Manager will audit the dietary schedule weekly for 3 months to ensure that the kitchen continues to be adequately staff and the dietary menus are not being changed without the Dietary Manager□s approval. The finding of the audits will be reviewed in the monthly QAPI meeting and changes made to the plan as needed to ensure continued facility compliance.	

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During an interview Dietary Aide #3 on 04/28/22 at 1:16 PM, Dietary Aide #3 reported she had to work by herself the evening of 04/24/22. She stated when she arrived to the facility and realized she was the only staff member in the kitchen, she tried multiple times, unsuccessfully, to reach the Dietary Manager. She stated she looked at the menu and knew she was not going to be able to cook the planned menu and get it to the residents at a reasonable time, so she changed the menu and made chicken salad on lettuce with crackers, and ham and cheese sandwiches with chips. She provided tea, milk, and water to drink. She reported she could not get the Dietary Manager on the phone, so she made the decision to change the meal on her own.

During an interview with the Dietary Manager on 04/28/22 at 3:20 PM, she reported she felt there was enough staff scheduled to get the work done timely. She reported there were times when meal trays were a little late to the halls but indicated it was not a routine problem. She also reported not receiving any telephone calls from Dietary Aide #3 on 04/24/22 regarding only one staff member working the evening shift on 04/24/22. She reported she found out on 04/25/22 when she arrived at the building.

During an interview with the Regional Dietary Manager on 04/28/22 at 3:27 PM, he reported there had been some staffing challenges but stated he felt the staffing had gotten better since he became more involved. He stated any call outs should contact the Dietary Manager and fill-ins be notified. He admitted that one staff member for the evening meal would "not be ideal, but stated he felt the job could be completed. He

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F 802	Continued From page 62 stated he thought that one dietary aide should be able to cook, plate, serve, and clean up for the evening meal but admitted if there was only one dietary aide, they would not be able to get the meals out to the hall timely. During an interview with the Administrator on 04/29/22 she reported she was aware of staffing issues within the kitchen and was aware the Dietary Manager did not assist the staff when there were staffing "challenges." She stated she has had several conversations with the company the facility contracted with about her concerns with little result. She reported she expected to have sufficient staff in the kitchen to ensure meals were cooked and delivered to the residents timely. She reported "Every meal this week has been late" and reported she would like 3-4 dietary staff in the kitchen on each shift and that one dietary aide on a shift was "absolutely not" enough.	F 802		
F 803 SS=F	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as	F 803		5/28/22

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F 803	Continued From page 63 input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on record review and facility staff and resident interviews, the facility failed to provide the planned evening meal for residents. This affected all residents who were served an evening meal. The findings included: A review of facility provided menus revealed on 04/24/22 the scheduled evening meal consisted of the following: "Country baked pork chops, orange twist, buttered white rice, fried okra, dinner roll, margarine, pineapple tidbits, whole milk, hot coffee or hot tea, creamer, one salt packet, one pepper packet, and one sugar packet." During an interview with an alert and oriented resident on 04/26/22 at 2:32 PM, he reported on Sunday, 04/24/22, he received a ham and cheese sandwich for his evening meal instead of what was on the menu. He could not remember what was scheduled to be served but he knew he did not receive what was originally on the schedule.	F 803	1. The evening meal served on Sunday 4/24/22 was not the meal scheduled per the menu. 2. The facility current residents could be affected by the failure to provide planned evening meals. 3.Dietary staff to include agency dietary staff will be education by the Dietary Manager by 5/27/22 on making sure residents are receiving the planned dietary meals. If the menu is changed, the changes will be posted in writing prior to the meal. New hires and agency staff will not be allowed to work until the education is completed. 4.The Dietary Manger will complete weekly audits for 3 months to ensure residents are receiving the planned dietary meals and substitutions are approved by the Dietary Manager. The results of the audits will be reviewed in the monthly QAPI meeting for 3 months to ensure continued facility compliance.	

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F 803	Continued From page 64	F 803		

During an interview with Dietary Aide #3 on 04/28/22 on 04/28/22 at 1:16 PM, she reported when she arrived for her shift in the afternoon of 04/24/22, she realized she was the only dietary staff member working. Dietary Aide #3 stated she was scheduled as the cook for the shift and normally served as a cook when she worked. She stated she tried unsuccessfully to contact the Dietary Manager multiple times to request assistance. She reported she knew she was going to be unable to get the scheduled meal out to the residents in a timely fashion since she was the only staff member in the kitchen, so she changed the evening meal to chicken salad served on lettuce with crackers, or a ham and cheese sandwich with potato chips. She stated she felt the changed menu would be the only meal she could prep, cook, and serve timely. Dietary Aide #3 reported she did not receive approval for the meal changes because the Dietary Manager failed to answer her phone calls. She reported, "I was doing the best I could considering I was the only staff member in the kitchen."

During an interview with the Dietary Manager on 04/28/22 at 3:20 PM, she reported she did not receive any telephone calls from Dietary Aide #3 on 04/24/22 and indicated that menu changes should not occur unless approved. She stated she was unaware that Dietary Aide #3 worked alone until she arrived at the facility, the morning of 04/25/22.

During an interview with the Regional Dietary Manager on 04/28/22 at 3:27 PM, he reported all changes to the scheduled meals should be approved by him or the Dietary Manager and the change should be recorded on the "Menu

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F 803	Continued From page 65 Substitution Log". He also stated that dietary aides should follow the scheduled menu and his company's policy regarding menu substitutions. During an interview with the Administrator on 04/29/22 at 1:56 PM reported the dietary aide should have tried to contact her when she realized she would be working alone in the kitchen. She stated she would have tried to get in touch with the Dietary Manager or the Regional Dietary Manager to try and get more help in the building or come up with an approved menu change. The Administrator stated menus should be followed when possible.	F 803		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 812		5/28/22

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F 812	Continued From page 66 Based on observations and facility staff interviews, the facility failed to label, and date opened food items in 1 of 1 walk-in refrigerators, and 2 of 2 nourishment room refrigerators, and failed to remove expired food items from 1 of 1 walk-in refrigerators, 1 of 1 reach in refrigerators, and 2 of 2 nourishment rooms, and failed to ensure the walk-in refrigerator and walk in freezer were free from dirt and debris. These practices had the potential to affect food served to residents. The Findings Included: 1. A. During a kitchen walkthrough completed on 04/25/22 at 10:22 AM an observation of the walk-in refrigerator revealed an opened, undated foam drinking cup of sliced pickles in juice, and a zip closure plastic bag of sliced green peppers that was undated and with milky film, brown water, and black spots. There were also 192 hardboiled eggs with a use by date of 04/18/22, and 4 unopened 32-ounce containers of thickened dairy drink that expired on 03/10/22. B. During a kitchen follow-up visit on 04/27/22 at 11:56 AM, an observation of the reach-in refrigerator revealed one opened 32-ounce container of thickened dairy drink that expired on 12/22/21. During an interview with the Dietary Manager on 04/27/22 at 11:59 PM, she stated the refrigerators were checked daily and items not dated or expired were removed. She did not know how the named items had been overlooked except by saying that the undated, opened pickles were probably used over the weekend and she had not	F 812	1. The identified items in the walk-in refrigerators, reach in refrigerators and the nourishment room refrigerators that were expired or not dated were discarded on 4/25/22 by the Dietary staff members and any dirt and debris was removed. 2. The walk-in refrigerators, reach in refrigerators, and the Nourishment room refrigerators were checked for expired and not dated items by the dietary manager on _5/19/22. Any expired or not dated foods/items were discarded and any dirt and debris was removed. 3. The Dietary Manager was educated on Next Level Policies & Procedures for Sanitation & Storage by the Regional Culinary Services on 5/19/22 The Dietary Manager educated the dietary staff to include agency dietary staff on Next Level Policies & Procedures for Sanitation & Storage and checking the Nourishment Rooms daily on 5/19/22. New hire dietary staff to include agency will not be allowed to work prior to completing the education.2. 4. Sanitation audits will be completed with a Next Level regional and the facility administrator one (1) time a week x 12 weeks on weekly sanitation audit form. Findings will be reported to the QAPI committee for review and recommendation. The administrator will present results of the audits to the quality assurance committee x 3 months. The QAPI committee may modify this plan to ensure the facility remains in compliance * (CMS mock survey tool will be used on next level app as seen below and monitored for increase/decrease in score)	

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F 812	Continued From page 67 had a chance to go through the refrigerators on 04/25/22 when they were found. She indicated there should be no expired food in the facility's refrigerators or freezers. During an interview with the Director of Culinary Services, on 04/28/22 at 3:27 PM, he reported all opened food items stored at the facility should be labeled, dated, and stored, per their policy. He also reported dietary aides should be checked the refrigerators daily and removing any expired food items. During an interview with the Administrator on 04/29/22, at 1:56 PM, she reported she expected food items to be labeled, dated, and stored appropriately and that expired food items be removed daily from the facility's refrigerators by either the dietary aides or the Dietary Manager. 2. An observation of the nourishment room just outside of the 700-hall door was made on 04/25/22 at 11:15 AM with the Dietary Manager (DM) and revealed the following items that were in the refrigerator or freezer and available for consumption: -a frozen chicken and broccoli meal with no name or date on it. -a frozen meatball marina with no name or date on it. -a frozen classic macaroni with beef with no name or date on it. -an opened jar of real mayonnaise with no name or open date on it. -2 cups of orange juice with no name or date on it. -chicken salad that contained a first name and 700 hall but no date on it.	F 812	Sanitation audits will be completed with a Next Level regional and the facility administrator one (1) time a week for 12 weeks on weekly. In addition, the dietary manager will complete an audit of the walk-in refrigerator, reach in refrigerator, and nourishment refrigerators 3 times a week to ensure proper food storage and sanitation practices to include removal of not dated and expired items and the refrigerators remains free of debris and dirt. The Administrator will report findings of the audits to the QAPI committee for 3 months for review and recommendation and will make changes to the plan as necessary to maintain compliance.	

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F 812	Continued From page 68 -a carton of mustard potato salad that expired on 04/21/22 with no name on it. -a carton of macaroni salad with no name or date on it. -a carton of Chinese takeout food with no name or date on it. -1 pimento cheese sandwich with no name or date on it and the bread was very stiff. -1 peanut butter and jelly sandwich with no name or date on it and the bread was very stiff. -2 chicken salad sandwich with no name or date on it and the bread was very stiff. -a plate of food that contained a resident name with no date on it. -a take out container that had a salad in it with wilted lettuce with no name or date on it. -a box of fried chicken with no name or date on it. -1 bologna sandwich with no name or date on it. -a carton of mustard potato salad that contained a resident name with no date on it that expired on 04/24/22. -a classic cob salad that expired on 04/06/22, the lettuce was covered with a green fuzzy substance. -a container of an unidentified food that had no name but contained a date of 03/01/22. There was a fuzzy green substances covering the unidentified food. - an open jug of diet green tea that had no name on it but expired on 03/21/22. -2 sandwiches that contained a resident name and date of 03/24/22. - an open carton of milk that expired on 04/11/22. -carton of thickened milk that expired on 01/11/22. -3 cups of yogurt that expired on 04/02/22. -2 cup of yogurt that expired on 03/25/22. -2 cups of yogurt that expired on 03/26/22. -1 cup of yogurt that expired on 04/11/22.	F 812		

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The DM was interviewed on 04/25/22 at 11:31 AM. The DM stated that the Dietary Aides (DA) checked the nourishment room refrigerator and freezer daily, but they were only checking for the items that the dietary department stocked. The other items were the responsibility of the nursing department. The DM was not able to articulate which DA had checked the nourishment room on 04/25/22. The DM added that there was no log of the checks it was just a part of their daily routine.

The Assistant Director of Nursing (ADON) was interviewed on 04/25/22 at 11:28 AM. The ADON stated that the dietary department should be checking the nourishment room refrigerator and freezers daily. She added that the nursing department or whoever placed food in the nourishment room would be responsible for labeling and dating the items with a resident name and the date. The ADON stated that the food should be discarded after 3 days by the dietary department when they made their daily check of the refrigerator and freezer.

The Director of Culinary Services (DCS) was interviewed on 04/28/22 at 3:08 PM along with the DM and the Administrator. The DCS stated that the nourishment room refrigerator and freezer should be checked daily and after 7 days the food should be discarded per their policy. The DM again stated that the DA had only been checking the items the dietary department stocked and was unaware that their policy directed them to check all food for expiration dates and discard anything that was 7 days or older. The Administrator stated that the nourishment room refrigerator and freezer should have been cleaned out and any undated or

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F 812	Continued From page 70	F 812		

unlabeled food or any expired food should have been discarded by the DAs on their daily checks of the nourishment room.

3. An observation of the nourishment room outside the nurses' station adjacent to the 300 hall with the Administrator on 04/25/22 at 4:29 PM revealed the following:

Items that were sitting at room temperature on the countertop and available for consumption:
a 4 quart partially consumed plastic container of applesauce with no label or date
9 cartons of whole milk with an expiration date of 05/02/22
an opened jar of partially consumed creamy peanut butter with no label or date
an opened jar of partially consumed grape jelly
an opened carton of partially consumed nutritional supplement
an opened cardboard box of sausage biscuits labeled keep frozen

Items that were in the freezer that were unlabeled:
2 chicken pot pies
an opened partially consumed bag of chimichanga's
an opened box of fruit and banana bites
pierced bags of resting on top of a dark brown smeared unidentifiable substance

The Administrator was interviewed on 4/25/22 at 4:30 PM. The Administrator stated the nourishment rooms should be checked daily by the dietary department to discard all unlabeled or undated items as well as out of date items. She indicated the housekeeping department should

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F 812	Continued From page 71	F 812		

check the nourishment rooms daily for sanitation.

The Director of Culinary Services (DCS) was interviewed on 04/28/22 at 3:08 PM along with the Dietary Manager (DM) and the Administrator. The DCS stated that the nourishment room refrigerator and freezer should be checked daily and after 7 days the food should be discarded per their policy. The DM again stated that the Dietary Aide (DA) had only been checking the items the dietary department stocked and was unaware that their policy directed them to check all food for expiration dates and discard anything that was 7 days or older. The Administrator stated that the nourishment room refrigerator and freezer should have been cleaned out and any undated or unlabeled food or any expired food should have been discarded by the DAs on their daily checks of the nourishment room. They were unable to determine who placed the food items on the counter and stated all food items that should be refrigerated or kept in the freezer should have been discarded since they were left out on the counter and were room temperature.

4. On 04/25/22 at 02:52 PM a large amount of a black/brown substance that was easily removable with a paper towel was observed on the walk-in cooler door and the walk-in freezer door.

On 04/26/22 at 09:15 AM a large amount of a black/brown substance that was easily removable with a paper towel was observed on the walk-in cooler door and the walk-in freezer door.

An interview with the Dietary Manager on 04/26/22 at 09:15 AM revealed the evening shift staff was supposed to wipe down the walk-in cooler door and walk-in freezer door daily and if

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F 812	Continued From page 72 they had been wiping the doors down as they should have been, the black/brown substance would not have been there. The Dietary Manager stated she expected the walk-in cooler door and walk-in freezer door to be clean and free of black/brown substances. An interview with the Administrator on 04/29/22 at 10:57 AM revealed she expected the kitchen to be clean and free of black/brown substances.	F 812		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interview the facility ' s Quality Assessment and Assurance (QAA) committee failed to ensure regulatory compliance with F880 and failed to maintain implemented procedures and monitor the intervention that the committee put into place on 07/26/21. This was for one repeat deficiency in the area of Infection Control that was originally cited on 06/25/21 during a recertification survey. The continued failure of the facility during the two federal surveys showed a pattern of the facility ' s inability to sustain an effective Quality Assessment and Assurance Program. The findings included:	F 867	1.Quality Assurance Process Improvement committee failed to maintain compliance with F880. An Ad Hoc committee was held on 4/27/22 with the Administrator, Director of Nursing, Medical Director, and The Regional Director of Clinical Services to discuss and provide education regarding F880. 2.All residents have the potential to be affected by a facility not having a QA process 3.The Regional Director of Clinical Services provided corporate policy education to the Administrator and Director of Nursing regarding the QAPI process on 4/27/22. 4.A Root Cause Analysis was completed	5/28/22

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F 867	Continued From page 73 This citation is cross referred to: F880: Based on observations, record review, and staff interviews, the facility: 1) failed to follow the "Special Droplet Contact Precautions" signage posted by the door of a resident's room when 1 of 2 nursing staff (Nurse Aide #7) did not don gloves and a gown prior to entering and remove her N95 mask upon exiting 1 of 1 resident room on droplet/contact precautions (Resident #12) and 2) failed to implement their infection control policies and procedures for hand hygiene when Nurse Aide #2 did not remove her gloves and wash hands after providing incontinence care for a soiled resident and before touching other items in the room for 1 of 1 nursing staff observed providing incontinence care to 1 of 1 sampled resident (Resident #4). During the recertification completed on 06/25/21 the facility failed to ensure a COVID-19 positive unit was labeled and personal protective equipment was readily available to staff outside the unit for 1 of 1 COVID-19 positive quarantine units. The facility further failed to ensure staff donned PPE according to the Enhanced Droplet Precautions Isolation sign posted on the door for 1 of 4 residents who resided on the observation quarantine unit. The facility also failed ensure proper glove usage and hand hygiene were completed when a nurse was observed performing a pressure ulcer treatment for 1 of 1 resident reviewed for pressure ulcers. The facility failed to ensure a residents personal clothing was not laundered with a facility incontinence pad for 1 of 1 resident reviewed for laundry. The Administrator was interviewed on 04/29/22 at 3:15 PM who stated that the QA committee	F 867	by the Administrator and Director of Nursing on 5/3/22 regarding Hand Hygiene and PPE. The staff are being re-educated on Hand Hygiene, PPE, Infection Control Basics by the Assistant Director of Nursing. The Administrator began a Quality Initiative on 5/3/22 with Alliant Health QIO regarding Hand Hygiene, Mask usage, and Donning/ doffing PPE. The Administrator will have a monthly conference with Alliant Health QIO Quality Improvement Initiative Advisor. Copies of the monthly QAPI will be reviewed with the Regional Director Clinical Services for the next 3 months to ensure progress.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 74 included all department heads and the Medical Director. She added that she planned to start inviting some of the direct care staff to come and be a part of the QA process as well. The Administrator stated that they currently had several things in the QA process including infection control and the results of the current complaint investigation would certainly be included in the next QA meeting. The Administrator stated that she had only been back at the facility for a month and had not had the time to get all the processes in place to help the facility achieve and maintain compliance.	F 867		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		5/28/22

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F 880	Continued From page 75 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed 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.	F 880		

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F 880	Continued From page 76 §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 observations, record review, and staff interviews, the facility: 1) failed to follow the "Special Droplet Contact Precautions" signage posted by the door of a resident's room when 1 of 2 nursing staff (Nurse Aide #7) did not don gloves and a gown prior to entering and remove her N95 mask upon exiting 1 of 1 resident room on droplet/contact precautions (Resident #12) and 2) failed to implement their infection control policies and procedures for hand hygiene when Nurse Aide #2 did not remove her gloves and wash hands after providing incontinence care for a soiled resident and before touching other items in the room for 1 of 1 nursing staff observed providing incontinence care to 1 of 1 sampled resident (Resident #4). Findings included: 1. The Special Droplet Contact Precautions signage, with a revised date of 02/09/22, noted staff should follow the instructions listed on the signage before entering the resident's room which included: "all healthcare personnel must: 1) clean hands before entering and when leaving the room, 2) wear a gown when entering room and remove before leaving, 3) wear N95 or higher level respirator before entering the room and remove after exiting, 4) wear protective eyewear (face shield or goggles), and 5) wear gloves when entering room and remove before leaving." The Centers for Disease Control and Prevention (CDC) guidance, last updated 02/02/22, noted in	F 880	1. NA #7 was educated on donning/doffing by Assistant Director of Nursing on when entering/exiting Special Droplet Contact Precaution Rooms. NA #2 was educated by Assistant Director of Nursing related to hand washing especially after removing gloves and providing incontinence care. Attestation, Root Cause Analysis, and timeline documents have been uploaded for review. 2Current residents and facility staff have the potential to be affected by staff failure to complete hand hygiene and failure to don/doff Personal Protective Equipment as required. 3.Facility staff to include agency staff will be educated by 5/27/22 by the Assistant Director of Nursing/ designees related to hand hygiene, donning/doffing PPEs and the infection Control policy. New hires and agency staff will not be allowed to work without the required education. The re-education of staff began April 2022. 4.Director of Nursing/ designee will audit 10 staff members to include agency staff weekly for proper Hand Hygiene and donning and doffing of Personal Protective Equipment for 4 week and monthly for 2 months. The Director of Nursing/ designee will present audits to the QAPI committee for 3 months for review and recommendation and will make changes to the plan to ensure	

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part, "Transmission-Based Precautions (quarantine) is recommended for residents who are newly admitted to the facility and for residents who have had close contact with someone with SARS-CoV-2 infection if they are not up-to-date with all recommended COVID-19 vaccine doses."

Resident #12 was admitted to the facility on 01/18/22. The admission Minimum Data Set (MDS) dated 01/25/22 assessed Resident #12 with intact cognition.

During an observation and interview on 04/26/22 at 1:05 PM, Resident #12 was currently on Special Droplet Precautions (SDCP) and stated he had received the first dose of the COVID-19 primary vaccination series and would be getting the second dose but wasn't sure when.

Review of the facility's surveillance line listing for residents and staff revealed on 04/06/22 an outbreak of COVID-19 was identified and new cases continued to be identified on 04/10/22, 04/11/22, 04/12/22, 04/13/22, 04/14/22, 04/18/22, 04/25/22, and 04/28/22.

During an observation on 04/26/22 at 12:52 PM, SDCP signage was posted on the wall directly beside the door. Nurse Aide (NA) #7 was observed wearing an N95 mask and goggles when she retrieved a meal tray from the meal cart and entered Room #113 without donning gloves or gown, placed the meal tray on the bedside table and moved the table closer to the resident. NA #7 then stepped back out into the hall, grabbed a pair of gloves from the Personal Protective Equipment (PPE) container located in the hall beside the room door and returned into Room #113 to assist the resident with

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repositioning without donning a gown. Prior to exiting the room, NA #7 doffed her gloves and washed her hands but did not remove her N95 mask after exiting. NA #7 then walked down the hall to the nurses' station.

During an interview on 04/26/22 at 12:58 PM, NA #7 revealed she had received infection control education related to donning/doffing PPE when entering and exiting resident rooms on isolation precautions. NA #7 confirmed she did not don a gown or gloves prior to entering Resident #12's room and did not doff her N95 mask upon exiting the room. NA #7 explained she did not notice the SDCP signage posted by the room door.

During an interview on 04/28/22 at 03:30 PM, the Director of Nursing (DON) stated staff were trained to read the precaution signage and follow the instructions for PPE to be worn. The DON confirmed Resident #12 was on SDCP due to his vaccination status and she would have expected NA #7 to don/doff PPE as instructed on the SDCP signage when entering/exiting the room. The DON added all staff were wearing N95 masks and goggles throughout the facility due to the current COVID-19 outbreak.

During an interview on 04/29/22 at 12:54 PM, the Administrator stated all staff were trained on isolation precautions and were expected to follow the instructions for PPE as specified on the signage.

2. Review of the facilty's policy titled "Hand Hygiene" last revised 10/29/20 read in part:

All staff will perform proper hand hygiene

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procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility.

A. "Hand hygiene" is a general term for cleaning your hands by handwashing with soap and water or the use of an antiseptic hand rub, also known as alcohol-based hand rub (ABHR).
B. Alcohol-based hand rub is the preferred method for cleaning hands in most clinical situations.
C. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves.

A continuous observation of Nurse Aide (NA) #2 on 04/26/22 from 11:23 AM to 11:32PM revealed NA #2 provided incontinence care for Resident #4. With gloved hands, NA #2 cleaned stool with resident care wipes and rolled up the soiled brief, dirty sheet, and draw-sheet and tucked it under Resident #4. While wearing the same pair of gloves used to remove stool, NA #2 rolled a clean sheet, clean draw-sheet, and clean brief under Resident #4. NA #2 assisted Resident #4 with rolling onto her right side and then onto her back, fastened the tabs on Resident #4's clean brief, pulled down Resident #4's gown, handed NA #5 a clean pillow case, and assisted NA #5 pull Resident #4 up in bed using the draw-sheet while continuing to wear the same pair of gloves used to remove stool. After Resident #3 was pulled up in bed, NA #2 removed her soiled gloves, discarded them in the trash, and performed hand hygiene.

During an interview with NA #2 on 04/26/22 at

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F 880	Continued From page 80 11:35 AM she confirmed she did not remove her gloves and perform hand hygiene after performing incontinence care. NA #2 stated she had been trained to remove her gloves and perform hand hygiene after performing incontinence care. She stated she did not discard her gloves and perform hand hygiene when providing incontinence care for Resident #4 because it was an oversight. An interview with the Director of Nursing (DON) on 04/29/22 at 10:32 AM revealed she expected staff to remove soiled gloves after performing incontinence care and perform hand hygiene before touching other items. An interview with the Administrator on 04/29/22 at 10:57 AM revealed she expected staff to remove soiled gloves and perform hand hygiene before touching other surfaces.	F 880		
F 886 SS=D	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with	F 886		5/28/22

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

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

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

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

§483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested.

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F 886	Continued From page 82 §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Center for Disease Control and Prevention (CDC) guidance for testing, and staff interviews the facility failed to ensure Health Care Personnel (HCP) not up to date with their Covid-19 vaccine were tested twice a week based on the community transmission levels and failed to ensure HCP were tested prior to reporting to their work area for 3 of 3 staff reviewed for infection control (Nurse #6, Nurse #7, and Nurse #3). This occurred during the Covid-19 pandemic. The findings included: Review of the CDC guidance last updated 02/02/22 titled, "Interim Infection Prevention and Control Recommendations to Prevent SARS-Cov-2 Spread in Nursing Homes" for expanded screening testing of asymptomatic HCP read in part: "In nursing homes, HCP not up to date with all recommended Covid-19 vaccine doses should continue expanded screening testing based on the level of community transmission as follows: nursing homes located in counties with substantial to high community transmission levels HCP should have a viral test twice a week. If HCP work infrequently ideally testing should be done within 3 days before their shift." Review of the facility's policy titled; "Coronavirus	F 886	1. Staff members #3, #6, and #7 were tested for COVID-19 and had negative results on 4/26/22 by the Director of Nursing. All residents have the potential to be affected by staff not routinely testing as per policy in accordance with CDC guidelines. 2. An audit was completed on 4/29/22 by the Administrator and Director of Nursing to ensure facility staff to include agency staff were tested as required. 3.Facility staff to include agency staff will be educated by the Assistant Director of Nursing on the testing cadence per Policy & Procedure and CDC guidelines by 5/27/22. Any newly hired staff and/or agency staff to be educated and tested for COVID-19 prior working on the floor. Signs have been placed throughout the facility to remind staff of COVID testing days and the importance of testing prior to you shift. 4. The director of Nursing/designee will complete audits of 10 staff members to include agency staff for 4 weeks to ensure COVID-19 testing is being completed according to the CDC guidelines and the Community Transmission testing cadence. The Director of nursing will submit the findings to the QAPI committee	

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Testing" last reviewed/revised on 03/10/21 read in part: "Testing of HCP who are not up-to-date with all recommended Covid-19 vaccine doses continue expanded screening testing twice a week when community transmission levels were substantial or high."

Review of the facility's surveillance line list for residents and staff revealed on 04/06/22 an outbreak of Covid-19 was identified, and new cases continued to be identified on 04/10/22, 04/11/22, 04/12,22, 04/13,22, 04/14/22, 04/18/22, 04/25/22, and 04/28/22.

Review of the CDC tracking of community transmission levels for the facility revealed Covid-19 levels were high for the weeks of 04/18/22 and 04/25/22.

a. Review of facility's Covid-19 testing log revealed on 04/19/22 Nurse #6 tested negative. The next test results dated 04/26/22 and 04/27/22 and were negative. There were no other test results prior to 04/19/22.

During an interview on 04/26/22 at 12:44 PM Nurse #6 confirmed she was not up to date with the Covid-19 vaccine and received the first and second dose but not the booster. Nurse #6 revealed she had only worked a couple of shifts at the facility and the facility provided testing twice a week on Monday and Thursday. Her most recent test was last Thursday on 04/19/22 and she was negative. Nurse #6 revealed she didn't work on 04/25/22 this past Monday the scheduled testing day and had not been tested prior to reporting to her work area on 04/26/22. Nurse #6 revealed her assignment for today was to provide care for approximately eleven residents. Nurse #6

meeting monthly for 3 months for review and recommendations to ensure the facilities continued compliance.

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also revealed her last shift on 04/19/22 was on the Covid-19 unit designated for positive residents. Nurse #6 revealed she forgot to be tested this week prior to reporting to her work area.

During an interview on 04/26/22 at 3:18 PM the Director of Nursing (DON) revealed she was the designated Infection Preventionist and stated staff were expected to test twice a week on the scheduled testing days Monday and Thursday. The DON revealed after she was made aware Nurse #6 was not tested on Monday, she was immediately tested on 04/26/22 and received a negative result.

b. Review of facility's Covid-19 testing log revealed Nurse #7 had received a negative test result on 04/26/22 and 04/27/22. There were no other test results prior to 04/26/22.

An interview was conducted with Nurse #7 on 04/26/22 at 12:48 PM. Nurse #7 confirmed she was not up to date with the Covid-19 vaccine and had received the first and second dose but not the booster. Nurse #7 revealed she worked for an agency staffing company and had worked at a different facility and tested negative for Covid-19 on 04/23/22. Today, 04/26/22 was her first day back and she had not been tested this week. Nurse #7 revealed the facility provided testing twice a week on Monday and Thursday and she was not aware she needed to be tested prior to reporting to her work area. Nurse #7 revealed her assignment was to provide care for approximately eleven residents.

During an interview on 04/26/22 at 3:18 PM the Director of Nursing (DON) revealed she was the

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designated Infection Preventionist and stated staff were expected to test twice a week on the scheduled testing days Monday and Thursday. The DON revealed after she was made aware Nurse #7 was not tested on Monday, she was immediately tested on 04/26/22 and received a negative result.

c. Review of facility's Covid-19 testing log revealed Nurse #3 received negative test result on 03/22/22, 03/29/22, 04/05/22, 04/12/22, 04/15/22, 04/19/22. There were no test results from 04/20/22 through 04/25/22.

An interview was conducted with Nurse #3 on 04/27/22 at 11:57 AM. Nurse #3 revealed she was fully vaccinated and had no symptoms of Covid-19. Nurse #3 revealed the facility tested staff twice a week on Tuesday and Thursday and her test last week was negative. Nurse #3 revealed she worked this past Monday on 04/25/22 and didn't test but would today being it's Tuesday the day staff were scheduled to test.

During an interview on 04/26/22 at 3:18 PM the Director of Nursing (DON) revealed she was the designated Infection Preventionist and stated staff were expected to test twice a week on the scheduled testing days Monday and Thursday. The DON revealed either her or the Assistant Director of Nursing (ADON) tested staff for Covid based on the daily schedule.

During an interview on 04/27/22 at 2:03 PM Nurse #3 revealed she was tested for Covid-19 and received a negative result.

An interview was conducted with Administrator on 04/29/22 at 12:53 PM. The Administrator stated

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F 886	Continued From page 86 the facility was currently in outbreak status and staff were expected to test twice a week based on the CDC community transmission levels. The Administrator revealed it was her expectation staff test on either on the scheduled test days or if not present prior to reporting to their designated work area.	F 886		
F 888 SS=C	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement. §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or	F 888		5/28/22

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	345179	A. BUILDING _____ B. WING _____	C 04/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

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telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and
(ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section.

§483.80(i)(3) The policies and procedures must include, at a minimum, the following components:
(i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents;
(iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19;
(iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section;
(v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC;

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(vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law;
(vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements;
(viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains:
(A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and
(B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications;
(ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma

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F 888	Continued From page 89 for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to implement the facility's process for tracking COVID-19 vaccination status for 17 of 21 contract staff reviewed for vaccinations (Nurse #8, Nurse #9, Nurse #10, Nurse #11, Nurse #12, Nurse #13, Nurse Aide (NA) #2, NA #5, NA #8, NA #9, NA #10, NA #11, NA #12, NA #13, NA #14, NA #15, and NA #16). The facility was currently in outbreak status. Findings included: The facility's "Employee COVID-19 Vaccination Mandate Policy" with a reviewed/revised date of 12/28/21, read in part: "it is the policy of the facility to ensure that all eligible employees are vaccinated against COVID-19 as per applicable Federal, State, and local guidelines. Compliance Guideline #2: Employees who provide any care, treatment or other services for the facility and/or its residents regardless of clinical responsibility or resident contact are required to be fully	F 888	1. The identified Contract nursing staff members (#8, 39, #10, #11, #12, #13, #2, #5, #8, #9, #10, #11, #12, #13, #14, #15, #16) vaccination cards were obtained by the Administrator on 4/27/22 All residents have the potential to be affected by staff not having their COVID-19 vaccination cards on file with the facility. The current schedules were compared to the COVID-19 vaccination cards by the Administrator on 4/29/22 to ensure all staff to include agency staff have vaccinations cards on file in the facility. 3.The Administrator and Director of Nursing were educated on the policy regarding COVID-19 vaccination cards by the Regional Director of Clinical Services on 4/27/22 The Administrator/ designee will educate the scheduler and the interdisciplinary team by 5/27/22 related to ensuring that the facility staff to include agency staff and	

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F 888	Continued From page 90 vaccinated against COVID-19 and include the following: facility employees, licensed practitioners, students, trainees, volunteers, and individuals under contract or by any other arrangement. The facility will track and securely document the vaccination status of each staff member (current and as new employees are onboarded) to include vaccination dates and copies of vaccination records." Review of the facility's surveillance line list for residents and staff revealed on 04/06/22 a COVID outbreak was identified and 22 residents had tested positive for COVID-19 as of 04/28/22. The facility COVID-19 staff vaccination spreadsheet provided by the Administrator on 04/25/22 was reviewed and compared to the 04/25/22, 04/26/22 and 04/27/22 daily staff schedules. The spreadsheet included in-house staff and contract/agency staff. There were 21 nursing staff listed on the daily schedules that were not included on the vaccination spreadsheet provided by the Administrator. A review on 04/26/22 of the National Healthcare Safety Network (NHSN) data for the week ending 04/10/22 revealed the following: Recent Percentage of Staff who are Fully Vaccinated = 100% During interviews on 04/26/22 at 3:20 PM and 04/28/22 at 4:01 PM, the Administrator revealed she was the one currently keeping track of staff vaccination status. The Administrator explained vaccination cards were obtained upon hire for facility staff and the Staffing Agencies the facility utilized were supposed to send her copies of contract staff vaccination cards. Once the	F 888	new hires will not be allowed to work in the facility without the required COVID-19 vaccination cards. 4.The Administrator/ designee will audit 10 random staff members from departmental schedules weekly for 4 weeks and then monthly for 2 months to ensure staff to include agency staff continue to have COVID-19 vaccination cards on file in the facility. The COVID 19 Vaccination Card Binder will be maintained in the Administrator's office by the Administrator. The Administrator will submit the findings to the QAPI committee meeting monthly for 3 months for review and recommendations to ensure the facilities continued compliance.	

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information was received from the Staffing Agency, she tried to organize them alphabetically in a notebook per agency. The Administrator added she also tried to keep the vaccination spreadsheet updated with the current vaccination information; however, she wasn't always able to update it daily or as soon as the copy of the vaccination card was received. Upon review of the staff vaccination spreadsheet and daily staff schedules for the period 04/25/22 to 04/27/22, the Administrator looked through the vaccination notebook and was able to provide copies of the vaccination status for 4 of the 21 facility and contract staff who were listed as working on the daily staffing schedules but was not included on the vaccination spreadsheet. The Administrator confirmed she was unable locate any paperwork regarding the remaining 17 contract staff vaccination status. The Administrator stated she had to reach out to the Staffing Agencies to obtain the missing information, as she had "found some holes" in the process, and now had all the vaccination information for facility and contract staff. The Administrator provided the information for the remaining contract staff which showed they had received all doses of the COVID-19 vaccination.