STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345365	A. BUILDING _____ B. WING _____	C 05/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF KINSTON	907 CUNNINGHAM ROAD KINSTON, NC 28501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation was conducted on 5/15/2022 through 5/24/2022. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #VBH811.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint survey was conducted from 5/15/2022 through 5/24/2022. Event ID #VBH811. Immediate Jeopardy was identified at: CFR 483.26 at tag F689 at a scope and severity (J) CFR 483.35 at tag F726 at a scope and severity (J) CFR 483.60 at tag F802 at a scope and severity (J) CFR 483.70 at tag F835 at a scope and severity (J) The tag F689 consituted Substandard Quality of Care. Immediate Jeopardy began on 05/11/2022 and was removed for F726, F802, and F835 on 5/19/2022 and removed for F689 on 5/20/2022. An extended survey was conducted. The following intakes were investigated: NC001184742, NC00184736, NC00182268, NC00182409, NC00182302, NC001877755, NC00187835, NC00187578, NC00188186, NC00180741, NC00178997, NC00188370. 24 of 43 complaint allegations were substantiated	F 000		

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

Electronically Signed | 06/17/2022

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F 000	Continued From page 1 resulting in deficiencies.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to honor a residents choice related to showers for 1 of 1 resident reviewed for choices (Resident #5).	F 561	F561 1. Resident #5 has been asked her preference regarding showers. Her	6/21/22

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F 561	Continued From page 2 Findings included: Resident #5 was admitted to the facility on 2/14/22 with diagnoses that included Parkinson's Disease and diabetes. The admission Minimum Data Set dated 2/21/22 revealed Resident #5 had moderate cognitive impairment. She needed limited assistance with transfers and was dependent on staff for bathing. It was very important for Resident #5 to choose between and bed bath and shower. Resident #5's care plan included resident's ability to perform activities of daily living: for example, transfer, walk in room, walk in corridor, dress, eat, toilet, maintain personal hygiene had deteriorated related to debility and Parkinson's Disease. On 5/19/22 at 8:53 AM Resident #5 stated she has had 4 showers in 5 weeks. She stated she had been asking to get a shower, but she was not getting them. During this interview resident was observed to have greasy hair and no odor. A review of the shower schedule indicated Resident #5 was supposed to be showered on Tuesday and Friday. An interview with Nursing Assistant (NA) #11, who was assigned to Resident #5, was conducted on 5/19/22 at 2:50 PM and she stated she did not offer showers to her residents today. She stated assignments were not given out until 8:00 AM and there was no time to do them. She also stated she didn't know there was a shower schedule.	F 561	preference is being honored and care planned accordingly. 2. All residents have the potential to be affected. In-house review of the current resident population to identify residents bathing preference to include showers. Care plans and resident care cards updated accordingly. Education provided by the Staff Development Coordinator for Licensed Nurses and Certified Nursing Assistants on resident bathing preference to include shower schedule by June 20, 2022. Newly admitted residents bathing preference will be obtained on admission and care planned. This education will be included in new hire orientation for Licensed Nurses and CNAs. 3. Ongoing audits to include resident interviews and observations will be completed by Director of Nursing, SDC, and/or Unit Manager to validate resident bathing preference is being honored to include adherence to the shower schedule. These audits will be completed on (5) residents 5 x weekly x 1 week, (5) residents weekly x 2 weeks, and (5) residents monthly x 3 months. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the DON or Assistant Director Of Nursing. Any issues or trends identified will be addressed by the QAPI committee as they arise, and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON,	

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F 561	Continued From page 3 An interview was conducted with NA #10 at 2:55 PM on 5/19/22 and she stated she didn't know there was a shower schedule. She stated baths were given to her residents. NA #4 was interviewed on 5/19/22 at 3:00 PM and she stated she did not offer showers to any her residents today but they were given baths. On 5/19/22 at 4:20 the Administrator stated he expected resident to get their showers if they want one.	F 561	ADON, SDC, MDS Coordinator, Admissions Coordinator, Rehabilitation Manager, Medical Director, and Director of Social Services. Other members may be assigned as the need should arise. 4. The Administrator and Director of Nursing is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by June 21, 2022.	
F 582 SS=B	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not	F 582		6/21/22

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F 582	Continued From page 4 covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide the required Centers for Medicare and Medicaid Services (CMS) Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) (form 10055) for 2 of 3 residents reviewed for beneficiary protection notification review (Resident #5 and Resident #2). The findings included:	F 582	F582 1.Resident #5 has been discharged from the facility. Resident #2's Resident Representative was notified on 6/7/2022 by the Business Office Manager about the Skilled Nursing Facility Advanced Beneficiary Notice (SNF-ABN).	

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F 582	Continued From page 5 1. Resident #5 was admitted to the facility on 2/14/22 with Medicare Part A skilled services. Resident #5's admission Minimum Data Set assessment dated 2/21/22 revealed she had moderate cognitive impairment. Resident #5's Medicare Part A skilled services ended on 3/8/22. She remained in the facility. Record review revealed no evidence that Resident #5 or the resident's responsible party were provided the CMS-10555 Skilled Nursing Facility Advanced Beneficiary Notice (SNF-ABN). The Notice of Medicare Non-Coverage (Form CMS 10123-NOMNC) was provided. During an interview with the Business Office Manager on 5/19/22 at 8:41 AM she stated there was an error in processing the notifications and Resident #5 received the NOMNC but did not receive the SNF-ABN. She reported she was responsible for providing the forms. She indicated Resident #5 had benefit days remaining. An interview was conducted with the Administrator on 5/19/22 at 10:45 AM who indicated Resident #5 should have received the CMS-10555 as required by Federal guidelines. He further stated he was unsure why the form was not provided by the Business Office Manager. 2. Resident #2 was admitted to the facility on 6/22/21. She was admitted to Medicare Part A skilled services on 1/18/22. Resident #2's Medicare	F 582	2.Residents who should receive the CMS-10055 Advanced Beneficiary Notice (SNF-ABN) as required by federal requirements have been identified as having the potential to be affected. In house, audit completed starting May 2022 to identify residents remaining in the facility and validate they have been provided notification of the SNF-ABN. 3.The Business Office Manager (BOM) was educated on 5/25/2022 by the Regional Business Office Coordinator (RBOC) on who should receive the CMS-10055 Advanced Beneficiary Notice (SNF-ABN) as required by federal requirements. This education will be included in the new hire orientation for Business Office Managers. 4. Ongoing audits to validate residents requiring the CMS-10055 Advanced Beneficiary Notice (SNF-ABN) have been provided as required by The Administrator or MDS Coordinator will audit five residents monthly for 3 months who no longer require skilled services to validate the CMS-10055 Advanced Beneficiary Notice (SNF-ABN) was provided. Results of the audits will be presented by the Administrator in the monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for three months. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the DON or ADON. Any issues or trends identified will be addressed by the QAPI	

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F 582	Continued From page 6 Part A skilled services ended on 1/25/22. She remained in the facility. Resident #2's annual Minimum Data Set assessment dated 5/11/22 revealed she had severe cognitive impairment. Record review revealed no evidence that Resident #2 or the resident's responsible party were provided the CMS-10555 Skilled Nursing Facility Advanced Beneficiary Notice (SNF-ABN). The Notice of Medicare Non-Coverage (Form CMS 10123-NOMNC) was provided. During an interview with the Business Office Manager on 5/19/22 at 8:41 AM she stated there was an error in processing the notifications and Resident #2 received the NOMNC but did not receive the SNF-ABN. She reported she was responsible for providing the forms. She indicated Resident #2 had benefit days remaining. An interview was conducted with the Administrator on 5/19/22 at 10:45 AM who indicated Resident #2 should have received the CMS-10555 as required by Federal guidelines. He further stated he was unsure why the form was not provided by the Business Office Manager.	F 582	committee as they arise, and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, ADON, SDC, MDS Coordinator, Admissions Coordinator, Rehabilitation Manager, Medical Director, and Director of Social Services. Other members may be assigned as the need should arise. 5. The Administrator is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by June 21, 2022.	
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with	F 585		6/21/22

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respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.

§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman

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program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement

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F 585	Continued From page 9 Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to document if a grievance was investigated and resolved, the results of the actions taken, if the complainant was satisfied and the complainant remarks. The facility also failed to address the complaint of the resident and failed to maintain documented evidence of a grievance that was filed by a resident. This occurred for 3 of 3 residents (Resident #17, Resident #370, and Resident #321) reviewed for grievances. Findings included: Review of the facility's "Investigate complaint/Grievance Policy" dated 3-24-22 documented in part that grievances/complaints and the corrective action would be documented on the grievance/complaint report form. Grievances/complaints would be investigated to include the nature of the grievance/complaint and all grievances/complaints would be resolved and reviewed by the Administrator within 3 working days of the receipt of the grievance/complaint. 1.Resident #17 was admitted to the facility on 10-3-12. The annual Minimum Data Set (MDS) dated 3-3-22 revealed Resident #17 was cognitively	F 585	F585 1. Resident #17, #370 and #321 grievances were resolved on June 20, 2022. 2. All residents have the potential to be affected. The Social Services Director and/or the Nursing Home Administrator (NHA) reviewed grievance log for the last 30 days to validate grievances were followed through to resolution by June 20, 2022. Incomplete grievances will be resolved and reviewed by the Administrator within 3 working days of the receipt of the grievance/complaint. The SSD will be educated by June 20, 2022 by the NHA on the Grievance Process and Grievance Resolution. This education will be included in new hire orientation for Social Services Directors. 3. Ongoing audits will be completed to validate grievance resolution via resident interviews and auditing of the grievance logs. These audits will be completed 5 x weekly for 1 week, weekly x 1 week and monthly x 3 months by auditing three grievances to validate resolution. All data will be summarized and presented to the	

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F 585	Continued From page 10 intact. Resident #17 was interviewed on 5-16-22 at 8:40am. The resident stated she had filed a grievance in April 2022 related to not receiving baths and incontinence care. Resident #17 said she had not received any information regarding her concern. Review of grievances for April 2022 revealed a grievance from Resident #17 dated 4-28-22. The grievance documented Resident #17 did not want a specified care giver because her care was not being provided. The form had the facility's Social Worker (SW) as the person completing the form and the name of the Staff Development Coordinator (SDC) and the name of the Unit Manager as the staff responsible for investigating the grievance. The areas of investigation, plan to resolve, results of actions taken, was the grievance resolved, complainant satisfaction and complainant remarks did not have any documentation. During an interview with the SDC on 5-18-22 at 9:15am, the SDC stated she was not aware she had been assigned a grievance to investigate. She explained the SW would receive the concern from the resident and then assign the grievance to which ever department the grievance pertained to. The SDC stated she had not been made aware of Resident #17's grievance dated 4-28-22. The Unit Manager was interviewed on 5-18-22 at 10:12am. The Unit Manager stated she had never seen Resident #17's grievance dated 4-28-22 and was not aware she was responsible for following up on the grievance. She stated the SW would assign the grievance to the department relevant	F 585	facility Quality Assurance and Performance Improvement meeting monthly by the DON or ADON. Any issues or trends identified will be addressed by the QAPI committee as they arise, and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, ADON, SDC, MDS Coordinator, Admissions Coordinator, Rehabilitation Manager, Medical Director, and Director of Social Services. Other members may be assigned as the need should arise. 4. The Administrator and Social Service Director is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by June 21, 2022.	

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to the grievance but again stated she was not made aware.

An interview with the SW occurred on 5-18-22 at 10:14am. The SW explained she presented the grievances in the department head meeting at 8:30am and then in the clinical meeting at 9:30am she would hand out the grievances to be followed up on to the correct discipline. The SW stated she remembered Resident #17's grievance dated 4-28-22 and said she had handed the grievance to the SDC to follow up with Resident #17. She said the SDC must have left it on the table and the grievance was placed back in the grievance book without being completed.

The Administrator was interviewed on 5-19-22 at 5:35pm. The Administrator explained the SW was responsible to ensure all grievances were followed up and completed. He stated he did not know why Resident #17's grievance was not completed but expected all resident grievances to be followed up and completed within 3 working days.

2. Resident #370 was admitted to the facility on 9-9-21

The quarterly Minimum Data Set (MDS) dated 1-26-22 revealed Resident #370 was cognitively intact.

Review of grievances from June 2021 through May 2022 revealed Resident #370 had a grievance dated 12-8-21. The document showed the grievance was received by the former Administrator and the contents was a concern by Resident #370 that a former nurse accused him of refusing his dressing changes. Resident #370

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stated in the grievance he was not refusing his dressing changes, but the former nurse was refusing to change his dressing. The resident also stated in the grievance he had text messages between him and the former nurse as proof she was refusing to change his dressing. The grievance indicated the concern was investigated by the former Administrator and the documentation for the investigation only included the concern of the resident texting with the former nurse. There was no documentation if Resident #370 was satisfied with the resolution or any remarks from the resident.

The Social Worker (SW) was interviewed on 5-19-22 at 2:28pm. She explained she was not employed at the facility at the time of Resident #370's grievance but after reviewing the grievance dated 12-8-21, the SW confirmed Resident #370's concerns were not addressed, and the grievance form should have been completed with the resident's satisfaction and remarks documented.

The Administrator was interviewed on 5-19-22 at 5:35pm. The Administrator stated investigations of grievances should focus on the complainants concerns and how the facility would resolve the concern.

3. Resident #321 was admitted to the facility on 2/10/22.

The admission Minimum Data Set dated 2/15/22 revealed Resident #321 had severe cognitive impairment.

An interview was conducted a Resident #321's family member on 5/16/22 at 6:10 PM and she stated she had talked to someone at the facility

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F 585	Continued From page 13 regarding concerns with the resident's care. She didn't recall who she spoke with at the facility. On 5/17/22 at 4:45 PM the Social Worker was interviewed, and she stated she was responsible for filling out the grievance form with the concern to be addressed and dispersing them to the appropriate staff for investigation. She remembered filling out a grievance form for Resident #321's family in March or April of 2022. The Social Worker explained the grievances filed were maintained in a hard copy grievance book and there was no grievance for Resident #321 in this book. The Social Worker stated on 5/18/22 at 10:45 AM after searching the facility for the grievance she was unable to locate it. On 5/19/22 at 4:22 PM an interview was conducted with the Administrator, and he stated he expected a copy of the grievances to remain in the grievance book until there was a resolution. Once there was a resolution, the original was kept in the grievance book.	F 585		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.	F 623		6/21/22

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(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights,

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including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the

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F 623	Continued From page 16 State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review, Ombudsman and staff interviews the facility failed to provide written notice of the reason for transfer to the resident and/or responsible party (RP) for 1 of 1 resident (Resident #41) reviewed for hospitalization and failed to send notice of transfers to the Ombudsman. Findings included: Resident #41 was admitted to the facility on 9/18/17. On 2/9/22 Resident #41 was discharged to the hospital and was readmitted on 3/15/22. The quarterly Minimum Data Set dated 4/18/22 revealed Resident #41 had severe cognitive impairment. An interview was conducted with the Social Worker on 5/17/22 at 11:47 AM and she stated she started in November 2021 and was unaware a notice with the reason for transfer was needed for the resident or RP. She also stated she had not been sending the notice of transfers to the Ombudsman. The Ombudsman was interviewed on 5/17/22 at 11:55 AM and she stated she had not received notice of transfers from the facility since January 2022.	F 623	F623 1. Resident #41 is currently discharged. 2. To ensure no other residents were affected, an audit of the discharged residents was completed, and notifications were provided for those affected starting the month of May 2022. Education on the written notification of discharge policy and the Ombudsman Notification Log was provided to the Social Services Director and/or Admissions Director. This education will be complete by June 20, 2022. This training will also be provided to all Social Services Directors upon hire during orientation. 3. Ongoing audits by the Administrator and/or MDS Coordinator for observation and review of proper notification of the Long-Term Care Ombudsman of resident's discharge will be conducted weekly for four weeks and monthly for three months. These audits will also include no less than 10% of the discharges from the center. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Administrator. Any issues	

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F 623	Continued From page 17 Nurse #6 was interviewed on 5/17/22 at 12:32 PM and she stated she was not aware a notice with the reason for the transfer was to be given to the resident or the resident's RP. On 5/17/22 at 4:45 PM and interview was conducted with Nurse #1, and she stated she discharged Resident #41 to the hospital on 2/9/22. She stated she called the family to let them know about the discharge but did not send a notice with the reason for transfer to the hospital. The Administrator was interviewed on 5/19/22 at 4:19 PM and he stated he expected a notice with the reason for the transfer to be sent to the resident or their RP and the Ombudsman to be notified.	F 623	or trends identified will be addressed by the QAPI committee as they arise, and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, Staff Development Coordinator, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise. 4. The Administrator or MDS Coordinator is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by June 21, 2022.	
F 625 SS=B	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with	F 625		6/21/22

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F 625	Continued From page 18 paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide the bed hold policy to the resident and the Responsible Party (RP) when the resident was discharged to the hospital for 1 of 1 resident (Resident #41) reviewed for hospitalization. This practice had the potential to effect other residents. Findings included: Resident #41 was admitted to the facility on 9/18/17. The quarterly Minimum Data Set dated 4/18/22 revealed Resident #41 had severe cognitive impairment. On 2/9/22 Resident #41 was discharged to the hospital and was readmitted on 3/15/22. Nurse #5 was interviewed on 5/17/22 at 12:10 PM and she stated she does not send the bed hold policy with the resident to the hospital or give it to the RP.	F 625	F625 1.Resident returned to the facility and the resident's bed was held. 2. All residents had the potential to be affected. Residents transferred to a hospital in the last 30 days were reviewed and residents were able to return as desired. Education on Facility Bed Hold policy was provided to the Licensed Nurses by the Staff Development Coordinator by June 20, 2022. This training will also be provided to Licensed Nurses upon hire during orientation. 3.Ongoing audits by the Director of Nursing and/or Unit Manager will be completed to include observation and record reviews to validate proper notification has been provided in writing to the resident and/or resident representative explaining how a resident's bed is held while the resident is absent from the facility due to the hospitalization.	

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F 625	Continued From page 19 On 5/17/22 at 12:32 PM Nurse #6 was interviewed, and she stated she was not sending the bed hold policy with the resident to the hospital or giving it to the RP. The interim Director of Nursing was interviewed on 5/17/22 at 3:00 PM and she stated she was unaware if the bed hold policy was being sent out when a resident is discharged or being provided to the RP. On 5/17/22 at 4:45 PM and interview was conducted with Nurse #1, and she stated she discharged Resident #41 to the hospital on 2/9/22. She stated she did not send the bed hold policy with Resident #41 to the hospital. She stated she didn't know the Resident and the RP needed to be notified of the bed hold policy when a resident was sent to the hospital. The Administrator stated on 5/19/22 at 4:20 PM he expected the bed hold policy to go with the resident when they are discharged to the hospital.	F 625	Additional auditing to include validation of the bed hold policy included in discharge paperwork. These audits will be conducted 5 x weekly for 1weeks, weekly for 2 weeks, and monthly for three months. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Administrator. Any issues or trends identified will be addressed by the QAPI committee as they arise, and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, Staff Development Coordinator, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise. 4. The Administrator and Director of Nursing are responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by June 21, 2022.	
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning	F 660		6/21/22

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process must be consistent with the discharge rights set forth at 483.15(b) as applicable and-
(i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident.
(ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.
(iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan.
(iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.
(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.
(vi) Address the resident's goals of care and treatment preferences.
(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.
(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.
(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.
(C) If discharge to the community is determined to not be feasible, the facility must document who

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F 660	Continued From page 21 made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to implement an effective discharge planning process and to ensure a resident had home health services and durable medical equipment in place as ordered by the physician prior to discharge for 1 of 1 resident reviewed for a planned discharge from the facility to the community (Resident #269). The findings included: Resident #269 was admitted to the facility on	F 660	F660 1. Resident #269 already discharged from the facility. Unable to issue discharge plan of care. 2. All residents had the potential to be affected. Audit completed of residents discharged in May 2022 to validate effectiveness of the discharge process and ensure durable medical equipment along with home health services are in	

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F 660	Continued From page 22 2/17/22 with diagnoses that included a cerebral infarction (stroke). Resident #269's admission Minimum Data Set assessment dated 2/24/22 coded him as having a moderate cognitive impairment, requiring limited assistance for most activities of daily living, and having the expectation to be discharged to the community. Resident #269 received physical (PT), speech (ST), and occupation therapy (OT) services while a resident of the facility. Resident #269's comprehensive care plan revealed a discharge goal dated 2/28/22 of access to necessary services to promote adjustment to new living environment post discharge from skilled nursing facilities. All interventions were marked as to be determined at discharge planning meeting. Review of a discharge summary completed by the social worker dated 4/18/22 revealed a discharge goal which read "Resident to discharge to home with home health services for PT, OT, ST. [Durable Medical Equipment] order: Wheelchair, metal ramp, and hospital be from an in-network provider. Discharge order obtained". Review of Resident #269's record revealed he was discharged home on 4/18/22. There was no evidence of a discharge planning meeting as indicated in the care plan and no further mention of discharge planning for Resident #269 from the time of admission (2/17/22) through the date of his discharge home (4/18/22). An interview was conducted with Resident #269's	F 660	place as ordered by the physician by June 20, 2022. Education on the discharge planning policy was provided to the Social Services Director by the Staff Development Coordinator by June 20, 2022. This training will also be provided to all Social Services Directors upon hire during orientation. 3. Ongoing audits by the Director of Nursing and/or Unit Managers for observation and review to ensure the discharge planning process is completed for discharged residents. These audits will be conducted weekly for four weeks and monthly for three months. These audits will also include no less than 10% of the discharges from the center. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Administrator. Any issues or trends identified will be addressed by the QAPI committee as they arise, and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, Staff Development Coordinator, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise. 4. The Administrator and Director of Nursing is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be	

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family member on 5/16/22 at 1:26 PM. She reported Resident #269 had not received any contact from home health services or any durable medical equipment. The family member stated the family was able to borrow a used hospital bed until the hospital bed arrived on 4/26/22. She reported Resident #269's wife was providing care for the resident and was receiving assistance from family members. The family member indicated Resident #269 was safe at home living with his wife due to family and community support. She revealed the facility had not contacted the resident or any of the family to follow up on Resident #269's discharge.

An interview was conducted with Social Worker #1 on 5/17/22 at 10:10 AM who stated the facility's protocol for the discharge planning process was to begin planning once a discharge date was received. Social Worker #1 stated she was advised of Resident #269's discharge date from his insurance company approximately one week prior to his discharge. The social worker stated she contacted two home health and durable medical equipment agencies who did not take Resident #269's insurance. She explained she sent over information and orders for Resident #269 to a third agency as they were the only provider that worked with his insurance. Social Worker #1 revealed she never received verification of receipt of the information sent to the third agency and she also received no confirmation they were accepting Resident #269 for services. She further revealed she had no contact with Resident #269 or his family after he was discharged.

An interview was conducted with the Administrator who stated Social Worker #1 was

completed by June 21, 2022.

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F 660	Continued From page 24 still learning her role and he was aware that discharge planning for Resident #269 was difficult due to insurance issues. He reported Social Worker #1 started in November 2021 and was trained by another social worker within the corporation. The Administrator indicated the Social Worker was responsible for ensuring that DME and services are in place for residents at the time of discharge. He indicated the facility would examine their discharge planning process.	F 660		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements	F 661		6/21/22

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F 661	Continued From page 25 that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete a recapitulation of stay for 1 of 1 resident reviewed for a planned discharge from the facility to the community (Resident #269). The findings included: Resident #269 was admitted to the facility on 2/17/22 with diagnoses that included a cerebral infarction (stroke). Resident #269's admission Minimum Data Set assessment dated 2/24/22 coded him as having a moderate cognitive impairment and having the expectation to be discharged to the community. Review of Resident #269's record revealed he was discharged home on 4/18/22. Further review revealed no evidence the facility completed a recapitulation of Resident #269's stay in the facility. The facility Social Worker #1 stated during an interview on 5/18/22 at 3:10 PM she was not aware who was responsible for completing the recapitulation of Resident #269's stay in the facility. During a second interview with Social Worker #1 on 5/18/22 at 4:18 PM she reported she was responsible for completing the recapitulation of Resident #269's stay in the facility. Social Worker #1 stated explained the Administrator advised her	F 661	F661 1. Resident #269 already discharged from the facility. Unable to initiate discharge summary in the closed record. 2. All residents had the potential to be affected. Discharge summaries to be completed on residents discharged in May 2022 and going forward. Staff Development Coordinator provided education on the discharge summary policy to the Licensed Nurses by June 20,2022. This training will also be provided to all Licensed Nurses upon hire during orientation. 3. Ongoing audits by the Director of Nursing and/or Unit Managers for observation and review to ensure the discharge summary process is completed for discharged residents. These audits will be conducted weekly for four weeks and monthly for three months. These audits will also include no less than 10% of the discharges from the center. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Administrator. Any issues or trends identified will be addressed by the QAPI committee as they arise, and the plan will be revised to ensure continued compliance. The QAPI	

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F 661	Continued From page 26 today that this was part of her responsibilities. She reported she was new to the social work role in the facility and began her position in November 2021. She reported she had been responsible for 3-4 additional community discharges since she began the position of social worker in the facility. An interview was conducted with the Administrator who stated Social Worker #1 was still learning her role and was not aware she was responsible for completing the recapitulation of Resident #269's stay in the facility.	F 661	committee consists of the Administrator, DON, Staff Development Coordinator, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise. 4. The Administrator and Director of Nursing is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by June 21, 2022.	
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review, observations, staff and resident interviews the facility failed to provide Activities of Daily Living (ADL) care to dependent residents. This occurred for 5 of 8 residents (Resident #53, #17, #46, #52 and #270) reviewed for ADL care. Findings included: 1.Resident #53 was admitted to the facility on 10-14-18 with multiple diagnoses that included dementia. The quarterly Minimum Data Set (MDS) dated 4-29-22 revealed Resident #53 was severely	F 677	F677 1. Activities of Daily Living (ADL) care has been provided for Resident #53, #17, #46, and #52. Resident #270 has been discharged. 2. All residents had the potential to be affected. An audit of the current resident population to ensure the delivery of ADL care to dependent residents. ADL care has been provided for all identified residents by June 16, 2021. The Staff Development Coordinator provided education to the licensed nurses and the	6/21/22

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F 677	Continued From page 27 cognitively impaired with no refusal of care and required extensive assistance with 2 people for bed mobility, total assistance with one person for dressing and toileting, total assistance with 2 people for personal hygiene and bathing did not occur. Resident #53's care plan dated 5-13-22 revealed a goal that he would be appropriately groomed and dressed. The interventions for the goal were in part provide ADL care to ensure daily needs were met. Review of Resident #53's ADL care documentation revealed no documentation that he had received any bathing for the following dates: - October 2021: 10/1, 10/2, 10/5, 10/7 - 10/10, 10/15 - 10/17, 10/19, 10/22 - 10/24, 10/27, 10/28, 10/20, 10/31 - November 2021: 11/2, 11/4, 11/6, 11/7, 11/11 - 11/13, 11/18, 11/20, 11/21, 11/24 - 11/29 - April 2022: 4/1, 4/2, 4/4, 4/11, 4/13, 4/16, 4/19, 4/22 - 4/30 - May 2022: 5/2, 5/10, 5/11, 5/13 ADL care for Resident #53 was observed on 5-17-22 at 9:15am with Nursing Assistant (NA) #4. Resident #53's skin was noted to be intact, however his brief was observed to be saturated through onto the beds under pad. The under pad was noted to have dried areas as well as wet areas. During an interview with NA #4 on 5-17-22 at 9:40am, the NA stated she had not provided incontinence care upon starting her shift or before breakfast and was not sure when Resident #53 had last received care. She stated she tried to	F 677	certified nursing assistants by June 20, 2022 on ensuring ADL care such as bathing and incontinent cares are being done for facility residents. This training will also be provided to all licensed nurses and certified nursing assistants upon hire during orientation. 3. Ongoing audits will be completed by the Director of Nursing, SDC, and/or the Unit Manager for observation and validation that ADL care has been provided for dependent residents. These audits will be conducted for (5) residents 5 x weekly for two weeks, (5) residents weekly for two weeks, and (5) residents monthly for three months. The DON, SDC, or Unit Manager will complete validation for newly admitted residents to ensure these residents received delivery of ADL cares. The DON, SDC, or Unit Manager will validate that newly admitted residents are receiving bathing cares and incontinent cares 5 days a week to ensure that all newly admitted residents are receiving ADL cares including bathing cares and incontinent cares x 4 weeks, then three times a week for 2 weeks, then weekly times 2 weeks. Any concerns identified will be corrected as observed. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Administrator. Any issues or trends identified will be addressed by the QAPI committee as they arise, and the plan will be revised to ensure continued compliance. The QAPI	

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F 677	Continued From page 28 check on her residents assigned to her every 2 hours for incontinence care. She revealed she did not perform a bed bath on all her residents assigned to her if the facility was short staffed. NA #4 explained she often had 18-20 residents assigned to her and could not perform ADL care on all of them. NA #5 was interviewed on 5-18-22 at 8:12am. The NA stated she was familiar with Resident #53 and had been assigned to provide ADL care to Resident #53 on 10-24-21 and 11-25-21. She said if she had not documented a bed bath was provided then she did not complete the task. She added Resident #53 had not refused ADL care. NA #5 explained the facility was often short staffed and she was not able to provide ADL care to all the residents she was assigned. A telephone interview occurred with NA #6 on 5-18-22 at 7:45pm. NA #6 confirmed she had worked the 11:00pm to 7:00am shift ending on 5-17-22. She stated she completed her last incontinence rounds between 4:00am and 5:00am but she stated she could not remember if she had provided incontinence care to Resident #53. The Administrator was interviewed on 5-19-22 at 5:35pm. The Administrator stated residents should have a bath every day and be provided incontinence care when it was needed. He stated he was aware the residents were sometimes not receiving bed baths prior to 4-25-22 but was unaware the problem had continued. 2. Resident #17 was admitted to the facility on 10-3-12 with multiple diagnoses that included muscle weakness, chronic obstructive pulmonary	F 677	committee consists of the Administrator, DON, Staff Development Coordinator, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise. 4. The Administrator and Director of Nursing is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by June 21, 2022.	

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disease and peripheral vascular disease.

The annual Minimum Data Set (MDS) dated 3-3-22 revealed Resident #17 was cognitively intact, had not refused care and required extensive assistance with 2 people for bed mobility, toileting and personal hygiene, and total assistance with 2 people for bathing.

Resident #17's care plan dated 5-13-22 revealed a goal that she would not have a decline with Activities of Daily Living (ADL). The interventions for the goal were in part provide extensive assistance for ADLs.

Review of Resident #17's bathing documentation revealed no documentation that a bed bath or any other bathing was provided for the following dates:
- October 2021: 10/2, 10/4, 10/22 - 10/24, 10/30, 10/31
- November 2021: 11/6, 11/14, 11/23, 11/25, 11/27, 11/28
- April 2022: 4/1 - 4/3, 4/7, 4/16, 4/20, 4/21, 4/24, 4/26, 4/30
- May 2022: 5/1, 5/3, 5/5, 5/8, 5/10, 5/13 - 5/15

Resident #17 was interviewed on 5-16-22 at 8:40am. The resident discussed not receiving a bed bath every day. The resident reported she did not want a shower but would like to have at least a complete bed bath daily. Resident #17 was observed to have a slight odor and the top of her gown was observed to have a dried substance.

NA #5 was interviewed on 5-18-22 at 8:12am. The NA stated she was familiar with Resident #17 and had been assigned to provide ADL care on 10-24-21, 11-23-21 and 11-25-21. NA #5 said if

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she had not documented that she had completed a bed bath on Resident #17, then she had not completed the task. The NA added Resident #17 had not refused ADL care. She explained the facility was often short staffed and she was not able to complete ADL care on all the residents she was assigned.

During an interview with NA #9 on 5-18-22 at 9:10am, the NA stated she was familiar with Resident #17 and had been assigned on 5-11-22 to provide ADL care. She stated if the care was not documented as completed then she was not able to complete a bed bath. She added Resident #17 had not refused ADL care. NA #9 explained the facility was short staffed at times and she was not always able to complete ADL care on all the residents assigned to her.

The Administrator was interviewed on 5-19-22 at 5:35pm. The Administrator stated residents should have a bath every day. He stated he was aware the residents were sometimes not receiving bed baths prior to 4-25-22 but was unaware the problem had continued.

3. Resident #46 was admitted to the facility on 3-1-16 with multiple diagnoses that included heart failure and peripheral vascular disease.

The quarterly Minimum Data Set (MDS) dated 4-26-22 revealed Resident #46 was cognitively intact, did not refuse care and required extensive assistance with one person for bed mobility, dressing, personal hygiene and total assistance with one person for toileting and bathing.

Resident #46's care plan dated 5-13-22 revealed a goal that she would maintain a clean, neat and

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odor free appearance while being cared for by staff. The interventions for the goal were in part help with Activities of Daily Living (ADL) care.

Review of Resident #46's bathing documentation revealed no documentation a bed bath or any other bathing was provided for the following dates:
- October 2021: 10/1, 10/3 - 10/10, 10/14, 10/16, 10/17, 10/19, 10/20, 10/23 - 10/25, 10/28, 10/31
- November 2021: 11/3, 11/4, 11/6 - 11/9, 11/11, 11/12, 11/15 - 11/17, 11/19 - 11/24, 11/26, 11/28 - 11/30
- April 2022: 4/2, 4/3, 4/6, 4/13, 4/15, 4/16, 4/19, 4/23, 4/24, 4/26, 4/28 - 4/20
- May 2022: 5/1, 5/7, 5/8, 5/10, 5/12, 5/14, 5/15

Resident #46 was interviewed on 5-16-22 at 9:45am. Resident #46 stated she did not receive ADL care every day but when she did the care was provided to her satisfaction. She explained she would prefer to have a bed bath every day, but she stated she understands the NAs are short staffed. Resident #46 was observed to have on a hospital gown that had a dried substance at the top of the gown.

NA #4 was interviewed on 5-17-22 at 9:30am. The NA stated she was familiar with Resident #46 and was assigned to her on 11-13-21 and 11-28-21 to provide ADL care. She said if there was not documentation on the days she was assigned to provide a bed bath, then the care was not provided. She added Resident #46 had not refused care. NA #4 explained the facility was often short staffed and she was not able to provide ADL care to all the residents she was assigned.

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NA #5 was interviewed on 5-18-22 at 8:12am. The NA stated she was familiar with Resident #46 and had been assigned to provide ADL care on 4-24-22. NA #5 said if she had not documented that she had completed a bed bath on Resident #46, then she had not completed the task. The NA added Resident #46 had not refused ADL care. She explained the facility was often short staffed and she was not able to complete ADL care on all the residents she was assigned.

During an interview with NA #7 on 5-18-22 at 4:10pm, The NA stated she was familiar with Resident #46 and stated she had been assigned to her for ADL care on 11-6-21. She said if there was not documentation of a bed bath on the days, she worked, then she did not complete the task. She added Resident #46 had not refused ADL care. NA #7 explained some days there were only 3 NAs for approximately 83 residents and she was not able to complete ADL care on all the residents she was assigned.

The Administrator was interviewed on 5-19-22 at 5:35pm. The Administrator stated residents should have a bath every day. He stated he was aware the residents were sometimes not receiving bed baths prior to 4-25-22 but was unaware the problem had continued.

4. Resident #52 was admitted to the facility on 2-24-20 with multiple diagnoses that included muscle weakness.

The quarterly Minimum Data Set (MDS) dated 4-28-22 revealed Resident # 52 was cognitively intact, did not refuse care and required extensive assistance with 2 people for bed mobility, personal hygiene, total assistance with 2 for

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toileting and total assistance with one for bathing.

Resident #52's care plan dated 5-13-22 revealed a goal that she would be appropriately groomed and dressed. The interventions for the goal were in part provide total assistance with 2 staff for Activities of Daily Living (ADL) care, provide ADL care to ensure daily needs are met.

Review of Resident #52's bathing documentation revealed no documentation a bed bath or any other bathing was provided for the following dates:
- October 2021: 10/1, 10/3 - 10/10, 10/14, 10/16, 10/19, 10/20, 10/23, 10/24, 10/29, 10/31
- November 2021: 11/2 - 11/4, 11/6-11/13, 11/15 - 11/26, 11/28 - 11/30
- April 2022: 4/1 - 4/4, 4/6, 4/13, 4/19, 4/23, 4/24, 4/26, 4/28 - 4/30
- May 2022: 5/1, 5/7, 5/10, 5/12, 5/15

Resident #52 was interviewed on 5-16-22 at 9:20am. The resident stated she was not receiving a bath daily and had to wait over an hour for incontinence care several times a week. She explained staff had told her they could not provide a bed bath to her some days and had to wait for care because there were not enough staff working. Resident #52 was observed to have an odor and colored liquid with a dried substance on the top of her hospital gown.

During a follow up interview with Resident #52 on 5-17-22 at 9:45am, the resident was in her bed and stated she needed her brief changed. She explained she asked a nursing assistant before breakfast at approximately 7:45am, but the nursing assistant told her she had to wait until after breakfast. Resident #52 stated she could

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not remember which nursing assistant she spoke with.

Observation of ADL care for Resident #52 occurred on 5-17-22 at 10:05am with Nursing Assistant (NA) #8. The observation revealed Resident #52's brief was saturated with urine through to the under pad on the bed.

An interview with NA #8 occurred on 5-17-22 at 10:30am. The NA stated she had checked Resident #52 for incontinence when she started her shift or prior to breakfast. She said she was unaware Resident #52 was assigned to her until the unit manager informed her at 10:00am. NA #8 stated she had not received a report about her residents assigned to her, so she did not know the last time Resident #52 had received care.

During a telephone interview with NA #6 on 5-18-22 at 7:45pm, the NA confirmed she worked the 11:00pm to 7:00am shift ending on 11-17-22. She stated she completed her incontinence rounds between 4:00am and 5:00am but she said she could not remember if she had provided incontinence care to Resident #52.

NA #4 was interviewed on 5-17-22 at 9:30am. The NA stated she was assigned to Resident #52 on 11-28-21. She stated if there was not a bed bath documented then she did not complete the task. She added Resident #52 had not refused care. NA #4 explained the facility was often short staffed and she could not complete bed baths on all the residents she had been assigned.

NA #5 was interviewed on 5-18-22 at 8:12am. The NA stated she was familiar with Resident #52 and had been assigned to provide ADL care on

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4-24-22. NA #5 said if she had not documented that she had completed a bed bath on Resident #52, then she had not completed the task. The NA added Resident #52 had not refused ADL care. She explained the facility was often short staffed and she was not able to complete bed baths on all the residents she was assigned.

An interview with NA #7 occurred on 5-18-22 at 4:10pm. NA #7 stated she had been assigned to Resident #52 on 11-6-21. She stated if there was not documentation that the resident received a bed bath then she had not completed the task. She added Resident #52 had not refused care. The NA explained the facility was short staffed and she was not able to complete bed baths on all the residents she was assigned.

The Administrator was interviewed on 5-19-22 at 5:35pm. The Administrator stated residents should have a bath every day and be provided incontinence care when it was needed. He stated he was aware the residents were sometimes not receiving bed baths prior to 4-25-22 but was unaware the problem had continued.

5. Resident #270 was admitted to the facility on 10/6/2021 with diagnoses including stroke.

The admission Minimum Data Set (MDS) assessment dated 10/12/2021 indicated Resident #270 was cognitively intact and required assistance with personal hygiene and bathing.

Resident #270's care plan dated 10/19/2021 included a focus in assisting him with his activities of daily living (ADL) due to left sided weakness. Interventions included providing assistance with person hygiene and bathing.

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A review of the facility's shower schedule revealed Resident #270 ' s showers were scheduled for Monday and Thursdays.

Documentation of Resident's #270 ADL care in October 2021 revealed no showers, bed baths or any other bathing was provided for the following dates:
October 2021: 10/6, 10/7, 10/8, 10/9, 10/10, 10/16, 10/17, 10/18, 10/19, 10/21, 10/22,10/23, 10/24, 10/25, 10/26, 10/27, 10/29, 10/30, 10/31

Resident #270 was discharged from the facility on 11/8/2021.

In a phone interview with Nurse Aide #12 on 5/18/2022 at 4:25 p.m., when asked if she provided Resident #270 a bath as the assigned NA on 10/7/2022, she stated she was unsure of the dates she assisted Resident #270 with baths, and she documented resident's baths in the electronic medical record. NA#12 had not documented assisting Resident #270 with bath on 10/7/2022 or was able to recall why a bath was not documented as given.

In a phone interview with Nurse Aide #13 on 5/18/2022 at 8:18 p.m., she stated she remembered providing Resident #270 a bed bath on 10/11/2021, and Resident #270 informed her that was his first bath since admission to the facility. She stated due to three to four nurse aides working on a shift, the nursing staff was unable to provide resident showers.

On 5/19/2022 at 4:32 p.m. in an interview with the interim Director of Nursing, she stated resident's baths and showers were based on the resident's preference, and nursing staff were to provide

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F 677	Continued From page 37 showers and baths as requested by the resident.	F 677		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, staff and Physician interviews the facility failed to provide supervision to prevent accidents when residents (Resident #369 and Resident #61) who were ordered to have nothing by mouth (NPO) and enteral feeding (nutrition delivered by a tube into the digestive system as a liquid) were served regular textured meals by Nursing Assistant (NA) #1. NA #1 fed Resident #369 a regular textured meal. Resident #369 aspirated (breathed food/liquid into the lungs) and was hospitalized for 5 days. NA #1 provided a regular textured meal tray to Resident #61. There was a high likelihood of serious harm for Resident #61. The facility also failed to maintain safe water temperatures for residents who performed activities of daily living (ADLs) independently. This was for 8 of 10 residents reviewed for supervision to prevent accident/hazards (Residents #369, #61, #47, #12, #35, #31, #171 and #32). Immediate Jeopardy for example #1 began on 5-11-22 when NA #1 fed Resident #369, who was NPO and on enteral feedings, a regular textured	F 689	F689 1. Resident #369 and Resident #61 remain NPO. Nurse aide #1 and the Assistant Dietary manager no longer work at the facility. Water temperatures have been corrected for Resident #47, #12, #35, #31, #171, and #32. 2. All residents have the potential to be affected. In house audit completed on diets of current resident population to review physician's diet order, diet care plans to match, and dietary tray card was completed by 5/13/2022 by the Interim DON, Unit Managers, or Dietary Director. Education provided by the Staff Development Coordinator to all staff on the need to provide a diet as ordered and the serious adverse outcomes that could result from providing an incorrect diet. The education also included where to find the diet order of the resident. This education was completed by 5/19/2022. This	6/21/22

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F 689	Continued From page 38 meal. Immediate Jeopardy for example #2 began on 5-11-22 when NA #1 provided Resident #61, who was NPO and on enteral feedings, a regular textured meal. Immediate Jeopardy was removed on 5-20-22 when the facility provided and implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of an "E" (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education, ensure monitoring systems put into place are effective, and to implement a plan of correction for examples 3 through 10. Findings included 1.Resident #369 was admitted to the facility on 9-22-17 with multiple diagnoses that included gastrostomy status. The quarterly Minimum Data Set (MDS) dated 4-13-22 revealed Resident #369 was severely cognitively impaired and required total assistance with one person for feeding. The MDS also coded Resident #369 as receiving 51% or more of her calories from tube feeding and 501cc (cubic centimeters) or more water per day. The May 2022 active physician's orders included an order initiated 7-26-21 for Resident #369 to receive a fortified nutritional supplement at 55cc per hour continuously through enteral feedings. The May 2022 active physician's orders included an order initiated 8-1-21 for Resident #369 to be NPO (Nothing by mouth). Resident #369's active care plan as of 5-10-22	F 689	education will be included in new hire orientation for all staff. Additional auditing completed on water temperatures in all resident rooms by June 20, 2022. Out of range water temperatures were corrected. Additional education was provided to the Maintenance Director and the Maintenance Assistant on the importance of maintaining safe water temperatures for residents who perform activities of daily living independently by the Regional Maintenance Director by June 20, 2022. This education will be included in new hire orientation for maintenance staff. 3. Ongoing auditing to include record reviews and observations to validate residents are provided accurate diets as per physician orders. Audits will be completed by the Director of Nursing and/or Unit Manager 5 x weekly for two weeks, weekly x two weeks, and monthly x 3 months. Additional audits of the water temperatures will be completed to validate maintenance of safe water temperatures by the Maintenance Director and/ or Maintenance Assistant. These audits will be completed 5 x weekly for two weeks, weekly for two weeks, and monthly x 3 months. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the DON or Assistant Director Of Nursing. Any issues or trends identified will be addressed by the QAPI committee as they arise, and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON,	

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revealed a goal that she would remain free of complications related to the use of a feeding tube. The interventions for the goal were in part keep head of the bed elevated, observe for abdominal distention, lung sounds and check for residual. Resident #369 had a second goal that her weight would remain stable. The interventions for the goal were in part resident is NPO, diet as ordered- fortified nutritional supplement and water flushes per order.

A nursing progress note dated 5-11-22 at 9:15am by Nurse #2 documented she was called into Resident #369's room by the Wound Care (WC) nurse. Nurse #2 documented she observed the resident with her eyes open, alert to tactile (physical touch) stimuli and coughing up blood-tinged fluid. The documentation indicated the Physician and family members were notified that Resident #369 was being sent to the emergency room for evaluation.

The emergency room hospital records dated 5-11-22 revealed a diagnosis of aspiration of food. A CT scan (series of x-ray images) was ordered which showed Resident #369 also had pneumatosis (increased gastric pressure in the colon due to vomiting) along the right colon.

The hospital records dated 5-16-22 indicated Resident #369 received intravenous fluids, intravenous antibiotics and was restarted on her enteral feedings. The resident was discharged back to the facility on 5-16-22

During a phone interview with NA #1 on 5-17-22 at 1:31pm, the NA explained 5-11-22 was her first day working at the facility. She added that it was only her 2nd time working in a long-term care

ADON, SDC, MDS Coordinator, Admissions Coordinator, Rehabilitation Manager, Medical Director, and Director of Social Services. Other members may be assigned as the need should arise.

4. The Administrator and Director of Nursing is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by June 21, 2022.

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facility. She discussed handing out breakfast trays on 5-11-22 and realizing Resident #369 and another resident (Resident # 61) had not received a meal tray. NA #1 stated she went to the kitchen and requested 2 meal trays (one for Resident #369 and one for Resident #61) from dietary staff. She said the dietary staff provided her 2 regular textured meal trays with eggs, French toast with apples, sausage patty and orange juice and commented the dietary staff had not mentioned to her the residents were NPO. NA #1 stated she went back to the unit, placed Resident #61's tray on the tray table and proceeded to Resident #369 where she began to feed the resident some of the eggs and orange juice. She stated Resident #369 began to turn red in the face and had trouble breathing, so she turned the resident on her side and retrieved help from a nurse that was in a meeting. She explained she did not see any nurses on the unit and had left the resident for approximately 1 minute to get help. NA #1 said she had received no orientation, training or computer access prior starting her shift. She stated she saw the enteral feeding pump for Resident #369 but did not know what it was and since she did not have access to the computer to check the resident's diet, she was unaware the resident was NPO.

The WC nurse was interviewed on 5-17-22 at 2:12pm. The WC nurse discussed being in a morning meeting on 5-11-22 when NA #1 entered the meeting requesting help. She stated when she walked into Resident #369's room, she saw dark red mucous on the resident's face and sheets. The WC nurse said the resident was sitting up in the bed and NA #1 told her she had been feeding the resident breakfast when the resident became ill.

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Nurse #2 was interviewed on 5-17-22 at 12:39pm. The nurse explained she was called down to Resident #369's room on 5-11-22 and observed the resident sitting up in the bed, coughing with blood-tinged fluid coming out of her mouth. She further explained the WC nurse had informed her NA #1 had been trying to feed the resident a meal. She stated she called the Physician, 911 and the resident's family. The nurse stated the resident was sent to the emergency room for further evaluation.

Dietary Aide #1 was interviewed on 5-17-22 at 1:20pm. The Dietary Aide stated she was working on 5-11-22 during breakfast but was assigned to the washroom and did not hand NA #1 any meal trays. She explained the Assistant Dietary Manager had spoken with and handed the meal trays to NA #1.

A telephone interview occurred with the Dietary Assistant Manager on 5-17-22 at 1:56pm. The Dietary Assistant Manager stated NA #1 had come to the kitchen on 5-11-22 requesting meal trays for Resident #369 and Resident #61. He discussed checking the dietary orders for both residents and saw they were both NPO and received enteral feedings but explained he thought staff was trying to switch the residents back onto solid food, so he provided a regular meal tray for both Resident #369 and Resident #61 to NA #1. The Dietary Assistant Manager stated he could only see a resident's dietary order in the computer. He explained that sometimes the orders were not entered into the electronic medical record before trays were passed out, so he did not know if there had been an actual order to switch the residents back onto solid foods. He

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revealed he should have asked the Dietary Manager or the nursing staff before providing the trays to NA #1.

The Medical Director was interviewed by telephone on 5-19-22 at 3:35pm. The Medical Director stated she was aware of the 5-11-22 incident for Resident #369. She indicated there was high potential for serious harm resulting from a resident aspirating.

The Director of Nursing (DON) was interviewed on 5-17-22 at 2:25pm. The DON stated the accident with Resident #369 could have been avoided if NA #1 had been oriented and educated regarding the resident's care prior to receiving her assignment.

2. Resident #61 was admitted to the facility on 7-6-11 with multiple diagnoses that included gastrostomy status.

The May 2022 active physician's orders included an order initiated 7-31-21 for Resident #61 was to be NPO.

The May 2022 active physician's orders included an order initiated 1-7-22 for Resident #61 to receive a fortified nutritional supplement at 45cc (cubic centimeters) per hour continuously through enteral feedings.

The quarterly Minimum Data Set (MDS) dated 5-9-22 revealed Resident #61 was severely cognitively impaired and required total assistance with one person for eating. Resident #61 was also coded for tube feeding acquiring 51% or more of her calories per day with 501cc (cubic centimeter) or more of water per day.

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Resident #61's active care plan as of 5-10-22 revealed a goal that she would not exhibit overt signs and symptoms of complications related to her feeding tube. The interventions for the goal were in part administer feedings as ordered, resident is NPO (nothing by mouth) and elevate the head of the bed 30-35 degrees while feeding.

During a phone interview with NA #1 on 5-17-22 at 1:31pm, the NA explained 5-11-22 was her first day working at the facility. She added that it was only her 2nd time working in a long-term care facility. She discussed handing out breakfast trays on 5-11-22 and realizing Resident #61 and another resident (Resident # 369) had not received a meal tray. NA #1 stated she went to the kitchen and requested 2 meal trays (one for Resident #61 and one for Resident #369) from dietary staff. She said the dietary staff provided her 2 regular textured meal trays with eggs, French toast with apples, sausage patty and orange juice and commented the dietary staff had not mentioned to her the residents were NPO. NA #1 stated she went back to the unit, placed Resident #61's tray on the tray table next to the residents bed. She commented Resident #61 would not have been able to reach the tray then stated she proceeded to Resident #369's room. NA #1 stated she had not fed Resident #61 but said another staff could have tried to feed Resident #61 since she left the meal tray in the room. NA #1 said she had received no orientation, training or computer access prior starting her shift. She stated since she did not have access to the computer to check the resident's diet and she was unaware the resident was NPO.

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A telephone interview occurred with the Dietary Assistant Manager on 5-17-22 at 1:56pm. The Dietary Assistant Manager stated NA #1 had come to the kitchen on 5-11-22 requesting meal trays for Resident #61 and Resident #369. He discussed checking the dietary orders for both residents and saw they were both NPO and received enteral feedings but explained he thought staff was trying to switch the residents back onto solid food, so he provided a regular meal tray for both Resident #61 and Resident #369 to NA #1. The Dietary Assistant Manager stated he could only see a resident's dietary order in the computer. He explained that sometimes the orders were not entered into the electronic medical record before trays were passed out, so he did not know if there had been an actual order to switch the residents back onto solid foods. He revealed he should have asked the Dietary Manager or the nursing staff before providing the trays to NA #1.

The Medical Director was interviewed by telephone on 5-19-22 at 3:35pm. The Medical Director stated she was aware of the incident on 5-11-22. She indicated there was high potential for serious harm from a resident who was NPO and fed solid foods to aspirate.

The Director of Nursing (DON) was interviewed on 5-17-22 at 2:25pm. The DON stated the potential accident with Resident #61 could have been avoided if NA #1 had been oriented and educated regarding the resident's care prior to receiving her assignment.

The Administrator was notified of Immediate Jeopardy on 5-17-22 at 6:05pm.

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

Resident #369's diet order: NPO
Resident #61's diet order: NPO

Nurse Aide #1, an agency staff, began working at the facility on 5/11/22 at approximately 7:00 AM. On 5/11/2022 during breakfast meal tray delivery Nurse Aide #1 recognized that Residents #369 and #61 had not received meal trays. She went to the kitchen and requested meal trays for both residents and was provided trays with regular textured meals from the Dietary Assistant Manager. At approximately 8:40 am, Nurse Aide #1 delivered a breakfast tray to Resident #369's room and the breakfast tray was placed on the bedside table of Resident #61 (out of residents' reach). Resident #369's tray consisted of scrambled eggs, sausage patty, French toast, apples, and orange juice. Both residents had the same items on the trays.

Nurse Aide #1 sat down to feed Resident #369. Shortly thereafter, resident appeared to have some difficulty and Nurse Aide #1 gave her orange juice. Resident's color appeared red. Nurse Aide #1 turned resident on her side and called out for nursing assistance. Arriving nurse reported resident began to vomit bloody emesis (vomit). Staff called MD and 911 and the resident was sent to the hospital at approximately 9:40 am, while alert and oriented, for further evaluation and treatment. At no time did Resident #369 stop breathing or lose consciousness during event.

A staff member (unknown) immediately removed the meal tray from Resident #61's room when

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staff became aware of the concern with Resident #369. Resident #61 was not fed the regular textured tray.

Post event:
- Medical director notified, and in-depth ad hoc Quality Assurance & Performance Improvement (QAPI) meeting for this event held 5/11/2022, with the Interdisciplinary Team, Medical Director and Regional Nurse Consultant. The QAPI committee consists of the Administrator, Director of Nursing (DON), Staff Development Coordinator (SDC), Minimum Data Set (MDS) Coordinator, the Medical Director, Regional Nurse Consultant, Special Projects DON, and the Unit Manager.
- Plan developed. Root cause was determined to be the following: Nurse Aide #1's first day working at the facility was 5/11/2022 and she received no orientation or training prior to working on the floor. She had no long-term care experience and the failure to orient prior to working on the floor contributed to the deficiency. In addition, the facility failed to validate Nurse Aide #1's access to the electronic medical record. She had no access to the physician's orders or care plans to see what the diet orders were. Nurse Aide #1 failed to validate residents' diet with charge nurse prior to requesting a meal tray from dietary. The Dietary Assistant Manager failed to follow the policy to validate the tray card system and consult with the dietary manager and/or a licensed nurse to determine if there was a change in the residents' diet order prior to fixing a meal tray for two residents (Residents #369 and #61).
- Nurse Aide #1 no longer works at the facility. Her last day was 5/11/2022. Nurse Aide #1 did not return to the floor after the incident.
- Dietary Assistant Manager was suspended on

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5/11/2022. He remains on suspension, but termination was recommended on 5/17/2022.
- This event was submitted to the state as a reportable on 5/11/2022. The allegation of neglect was substantiated, and the final investigative summary was submitted on 5/18/2022.

All residents are at risk for the current deficient practice.

Plan developed:
- Diets of all current residents will be reviewed for physician's diet order, diet care plans to match, and dietary tray cards to match; this will be completed by 05/13/2022 by the Interim DON, Unit Managers, or Dietary Director. There were three resident diets corrected.
- All resident care plans and CNA care guides will be reviewed for matching level of meal assistance (set-up; supervision; encourage/cue; dependent on staff); this will be completed 05/16/2022 by the Interim DON, Unit Managers, or Minimum Data Set (MDS) Nurse. No discrepancy noted.
- Audit of past 30 days of grievances, events, and progress notes will be reviewed by the interim administrator and/or Regional Nurse Consultant by 05/13/2022, for purposes of assessing other events during resident meals and/or residents receiving improper diets/meal trays, to ensure appropriate steps. One grievance was identified related to the way the diet was ordered to ensure the correct meal consistency was provided to the resident. Diet has been corrected and clarified. There was no harm to the resident affected.
- Resident council meeting will be held by 5/17/2022 for any additional concerns meal/dietary concerns. Residents had no

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concerns regarding their food.
- Clinical licensed and unlicensed and dietary staff will be reeducated by the DON and/or SDC on (i) locating and verifying resident diet information if in question, (ii)proper set-up of resident meal trays: proper positioning of residents at mealtime (whether in dining room, resident room, wheelchair, and in bed), (ii) proper consistency of diets and liquids (e.g., regular, mechanical soft, pureed, nectar/pudding/honey thickened liquid), and (iii) checking resident tray cards when setting up resident meal tray to ensure matching. Reeducation will be completed by the IDT by 05/18/2022. No staff including agency staff will work on the floor after 5/18/22 until education has been received. Education provided by the DON and/or SDC on the facility's "Assistant with Meals" policy, ensuring residents are served the correct meal as ordered by validation of residents' diets using the CNA care guides, what NPO means, and how giving a resident the wrong diet could cause choking episodes, aspiration into the lungs, or subsequent death of the resident.
- The facility staff development coordinator immediately educated all staff on the need to provide a diet as ordered and the serious adverse outcomes that could result from providing an incorrect diet. This education was initiated on 5/17/2022 and completed on 5/19/2022. Education was also provided by the DON and/or SDC to agency staff and a post-test provided to validate understanding starting on 5/17/2022 and completed on 5/19/2022. All staff will complete and score 100% on the written post-test. This written test was completed on 5/18/2022 and included validation of the diet report, notification of the dietary manager if unsure of a diet request, training on diet textures including NPO diet, and

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reviewing all diet orders for accuracy in the meal tracking system. No staff including agency staff will work on the floor after 5/17/2022 until education has been received.

- The dietary staff were re-educated on the protocol in place to ensure meal trays are not provided to NPO residents unless ordered by the physician. A list of resident diets is printed and posted as a second reference for the dietary staff to validate a residents' diet. This education was provided by the Regional Dietary Manager on 5/18/2022. The list of resident diets was posted on the bulletin board in the kitchen. The dietary manager will keep the posting updated if changes are made.

- Additional education was provided to Dietary staff by the Director of Nursing that providing a diet not ordered for a resident could result in serious adverse outcomes. Re-education and a verbal re-test completed on 5/18/2022. Dietary staff required to attain a 100% by 5/18/2022 or they will not be allowed to work.

- Facility Staff Development Coordinator, Wound Nurse and/or Regional Nurse Consultant will ensure all staff have access to the electronic medical records system prior to the beginning of their first assigned work shift as of 5/16/2022. The on- call clinical team member or weekend manager will be responsible for the EMR access validation as stated above for the agency orientation process. No nursing staff will work on the floor after 5/16/2022 without access to the electronic medical records system. Orientation on the electronic medical record will be completed with the agency staff by the facility wound nurse, staff development coordinator, and/or the regional nurse consultant. The Agency Orientation Checklist includes education on how to use the medical records system. In addition,

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the Clinical Team Member or Weekend Manager are responsible to audit agency staff and validating staff are accessing the electronic medical record for resident care needs. The agency staff are also instructed on the use of the care delivery guides for information on each resident's care needs prior to working on the floor.

- The facility has provided the staffing agencies a copy of the agency orientation guide on 5/12/22. Agency staff will present to the facility with a signed orientation packet. Agency staff will not be permitted to work until this agency orientation material has been completed. The number to the on-call phone has been posted at each nurse's station for agency staff to receive this education over the phone and complete agency orientation guides have been placed at each nurse's station for reference. A Clinical Team Member rotation, consisting of either the Director of Nursing, Wound Care Nurse, or Staff Development Coordinator, will have the on-call phone on off hours and weekends and will be available to staff to conduct training and other assistance as needed. Should the agency staff arrive to the facility without the orientation packet completed, the agency staff will be directed to contact the on-call phone/Clinical team member for the orientation process to be completed prior to beginning their assignment. The on-call clinical team member will be responsible to be in the facility at the beginning of day shift and available on off hours and will be responsible to collect the agency staff orientation paperwork at the start of the shift or assist with the orientation process. In the afternoon hours of weekend days, approximately 2:45 pm - 7:00 pm, the Manager on Duty will be responsible to collect the agency staff orientation paperwork at the start of the

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afternoon shift, as previously established, or assist the agency staff in contacting the on-call clinical team member to complete the orientation process. The Clinical Team will be responsible to review the schedule daily, specifically on the weekend days, to determine who will be an agency staff person working at the facility for the first time and who will need to have validation of the orientation packet being completed prior to their arrival, or if it must be done on site prior to beginning their job duties. Education will also include information on residents who are NPO and/or fed by a tube. Additional education was provided by the Director of Nurses and Unit Manager for the nursing staff, going over the list of residents who are NPO, and adding list to the CNA care guide notebook located at each nurse's station. Centralized scheduling has been educated by Clinical Information Technology Nurse Technologist on providing agency staff access to the electronic medical record prior to arrival to the facility. If the access is not obtained prior to arrival, the agency staff will call the on-call phone number and access will be provided along with steps to access the system. Validation will be completed that electronic medical record access is successful prior to the staff working their shift. The on- call clinical team member or weekend manager will be responsible for the EMR access validation as stated above for the agency orientation process. This was implemented on 5/18/2022. Any staff, to include agency staff, who were not educated by 5/18/2022 will receive education prior to working on the floor.

Alleged date of IJ removal: 5/20/2022.

The facility's credible allegation of Immediate

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Jeopardy was validated onsite on 5-24-22 through interviews with facility staff including nursing staff and dietary staff as well as the Regional Consultant. The nursing staff verbalized receipt of education prior to starting their shift in the facility. The staff education documentation, audits and monitoring were reviewed. Nursing staff education included completing the orientation checklist and obtaining access to the facility's electronic medical record system prior to providing resident care, and the use of the resident care guides to locate resident care information including diets. Nurse aides were observed using resident care guides, located at the nursing station, to confirm resident's diets and stated resident diets were verified with nursing staff before requesting a diet tray from the kitchen. Dietary staff education included use of resident diet list to confirm a resident's diet and to clarify resident diets with the dietary manager or nurse as needed. Dietary staff stated resident dietary list was printed daily and used as a reference when nursing staff requested diet trays for residents, and a list of residents with nothing by mouth (NPO) diets and the resident diet list was posted in the kitchen. All resident diets were audited for accuracy, and daily meal audits indicated no issues with residents receiving the correct diets. Signage with contact information was posted at the time clock and both nursing stations reminding agency nursing staff not to provide resident care until obtaining access to the facility's electronic medical record and receiving the Orientation Checklist. Interviews with the nursing staff and a review of staffing audits revealed new agency staff were receiving access to the facility's electronic medical record and the orientation checklist information prior to or on the first day working in the facility and

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providing resident care.

The facility's date of immediate jeopardy removal of 5-20-22 was validated.
3. A review of the medical record revealed Resident #47 was admitted on 1/15/15.

The Annual Minimum Data Set (MDS) dated 4/27/22 noted Resident #47 was cognitively intact and needed extensive to total assistance for all daily care with the help of one person. Resident #47 could feed himself with altered utensils. Resident was in a motorized wheelchair when out of bed and could propel himself throughout the facility.

The care plan dated 4/29/22 noted a focus of Activities of Daily Living (ADL) function with interventions of: Resident has preferred routine of bath and out of bed by 7 AM. Provide assistance for toileting and hygiene.

On 5/16/22 at 10:30 AM, the Assistant Maintenance Director took hot water temperatures in bathroom sinks available to residents who had the ability to use the sink in the bathroom areas to perform self-care. There were residents in these rooms that were unable to perform self-care.

On 5/16/22 at 10:30 AM, accompanied by the Assistant Maintenance Director, the temperature in the bathroom area of Resident #47's room registered 118.9. The Assistant stated that was too high, and the mixing valve needed to be adjusted. Resident #47 was in the room and was asked if he went into the bathroom area to wash his hands and he stated "yes, I can take my chair in the bathroom and wash my hands." The

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Resident was encouraged by the Assistant Maintenance Director to turn on the cold water first with the hot water so he would not burn his hands.

At 4:55 PM on 5/16/22, Resident #47's sink hot water temperature was 121.5. The Assistant Director of Maintenance stated the mixing valve had been adjusted, the plumber was in the facility and the temperatures would be monitored throughout the evening.

On 5/17/22 at 2:00 PM, the Maintenance Director stated the plumber came, found rings in the mixing valve were flat and broken. The Director stated the mixing valve was repaired but water may require 24 hours to reach even temperatures, and the temperatures were being monitored.

On 5/18/22 at 9:20 AM, the temperature of the hot water in the bathroom area of Resident #47's room was 107.2.

4. A review of the medical record revealed Resident #12 was admitted on 8/31/20 with diagnoses of Diabetes Mellitus, debility, pain.

The Annual Minimum Data Set (MDS) dated 2/15/22 noted Resident #12 was cognitively intact and needed supervision to extensive assistance for all daily care with the help of one person. The MDS indicated Resident #12 could feed herself independently after tray set up.

The care plan dated 2/15/22 noted a focus of Activities of Daily Living (ADL) with an intervention of only do what is needed so resident can maintain ability.

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On 5/16/22 at 10:30 AM, hot water temperatures were taken in bathroom sinks available to residents who had the ability to use the sink in the bathroom areas to perform self-care.

On 5/16/22 at 10:35 AM, accompanied by the Assistant Maintenance Director, who took the temperatures, the temperature of the hot water in the bathroom area sink was 119.9. The Assistant Maintenance Director stated the mixing valve needed to be adjusted.

On 5/16/22 at 4:55 PM, hot water temperatures were rechecked. Resident #12's bathroom sink registered 120.1 Assistant Director of Maintenance stated the mixing valve had been adjusted, the plumber was in the facility and the temperatures would be monitored throughout the evening. Resident #12 stated she goes into the bathroom area and uses the bathroom and washes her hands.

The Maintenance Director was interviewed on 5/17/22 at 2:00 PM and stated the plumber had found rings in the mixing valve were flattened and broken. The Director stated the mixing valve was repaired but water may require 24 hours to reach even temperatures, and the temperatures were being monitored.

On 5/18/22 at 9:20 AM, Resident #12's hot water in the bathroom sink registered at 105.1.

5. A review of the medical record revealed Resident #35 was admitted on 12/29/20.

The Annual Minimum Data Set (MDS) dated 1/3/22 noted Resident #35 to be cognitively intact

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and needed only supervision or was independent for all daily care, with the assistance of one person.

The care plan dated 5/17/22 noted a focus of Activities of Daily Living (ADL) with interventions of provide assistance for ADLs as needed, consistent approach, and monitor for pain.

On 5/16/22 at 10:40 AM, accompanied by the Assistant Director of Maintenance, who took the temperatures, the temperature of the hot water from the sink in the bathroom area was 118.7. The Assistant stated that temperature was too high, and the mixing valve needed to be adjusted.

At 5:00 PM on 5/16/22 the hot water was found to be 124.8. the Assistant Director of Maintenance stated the mixing valve had been adjusted, the plumber was in the facility and the temperatures would be monitored throughout the evening.

On 5/17/22 at 2:00 PM, the Maintenance Director stated the plumber came, found rings in the mixing valve were flat and broken. The Director stated the mixing valve was repaired but water may require 24 hours to reach even temperatures, and the temperatures were being monitored.

Resident #35 was asked on 5/18/22 at 8:45 AM, if he used the bathroom area sink and he stated he did use it to wash his hands. Resident # 35 stated he had not noticed the water being too hot.

On 5/18/22 at 9:25 AM, the hot water in Resident #35's bathroom area sink registered at 106.3.

6. A review of medical records revealed Resident

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#31 was admitted on 3/17/14 with diagnoses including stroke, dementia, anxiety and obstructive uropathy.

The annual Minimum Data Set (MDS) dated 4/6/22 noted Resident #31 was cognitively impaired and needed extensive to total assistance with all daily care with the help of one person.

The care plan dated 5/16/22 noted a focus of Activities of Daily Living (ADL) self- care deficit and interventions of allow rest periods, total care for all ADLs, monitor for pain.

Resident #31 was interviewed on 5/16/22 at 10:40 AM and stated he could propel himself in his motorized wheelchair without difficulty and was observed moving throughout the facility in his chair, feeding himself and attending activities. Resident #31 stated he did go into the bathroom area and use the sink.

On 5/16/22 at 10:40 AM, accompanied by the Assistant Director of Maintenance, the temperature of the hot water from the sink was 118.7 in Resident #31 ' s bathroom area. The Assistant Director stated the temperature was too high and the mixing valve needed to be adjusted. The Assistant Director told Resident #31 and the roommate to be careful with the water because it wastoo hot.

At 5:00 PM on 5/16/22 the hot water was found to be 124.8. The Assistant Maintenance Director stated the mixing valve had been adjusted, the plumber was in the facility and the temperatures would be monitored throughout the evening.

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On 5/17/22 at 2:00 PM, the Maintenance Director stated the plumber came, found rings in the mixing valve were flat and broken. The Director stated the mixing valve was repaired but water may require 24 hours to reach even temperatures, and the temperatures were being monitored.

On 5/18/22 at 9:25 AM, the hot water in Resident #31's bathroom area sink registered 106.3

7. A review of medical records revealed Resident #171 was admitted on 5/6/22 with diagnoses including Diabetes.

The Admission Minimum Data Set (MDS) dated 5/11/22 noted Resident #171 was impaired for cognition. Resident #171 was observed feeding himself.

On 5/16/22 at 10:40 AM, accompanied by the Assistant Director of Maintenance, the temperature of the hot water from the sink in the bathroom area registered 118.7. The Assistant stated the temperature was too high and the mixing valve needed to be adjusted.

At 5:00 PM on 5/16/22 the temperature of the hot water from Resident #171's bathroom sink was 124.8. The Assistant Director of Maintenance stated the mixing valve had been adjusted, the plumber was in the facility and the temperatures would be monitored throughout the evening.

On 5/17/22 at 2:00 PM, the Maintenance Director stated the plumber came, found rings in the mixing valve were flat and broken. The Director stated the mixing valve was repaired but water may require 24 hours to reach even

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temperatures, and the temperatures were being monitored.

Resident #171 was observed sitting in his wheelchair on 5/18/22 at 8:52 AM and was asked if he rolls himself to the bathroom area and uses the sink. Resident #171 stated he did use the sink to wash his hands.

On 5/18/22 at 9:25 AM, the hot water in Resident #171's bathroom sink registered 106.3.

8. A review of the medical record revealed Resident #32 was admitted to the facility on 4/25/2019, and her diagnoses included stroke and arthritis.

A review of the census report revealed Resident #32 had resided in Room 205A since 4/26/2019.

Resident #32's care plan dated 10/29/2019 indicated a risk for deterioration in activities of daily living. Interventions included use of rolling walker or wheelchair, providing set up assistance and allowing extra time to complete her activities of daily living.

The quarterly Minimum Data Set (MDS) assessment dated 4/8/2022 revealed Resident #32 was moderately cognitively impaired and independently performed all of her activities of daily living. The MDS further indicated Resident #32 was always continent of urine and stool.

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On 5/16/2022 at 10:00 a.m., the Assistance Maintenance Director checked hot water temperatures in bathroom sinks that were available to residents who had the ability to independently use the sink in the bathroom areas to perform self-care. The temperature of the hot water of the 200-hall bathroom registered 121.9 degrees Fahrenheit. The Assistance Maintenance Director stated the hot water temperatures were checked every Monday, Wednesday and Friday, and the acceptable range was 108-116 degrees Fahrenheit. He stated the mixing values needed adjusting, and the Administrator and nursing staff was informed by the assistance maintenance director of the hot water temperatures.

On 5/16/2022 at 11:47 a.m. in an interview with Resident #32, she stated due to having no bathroom inside room 205A she used the 200-hall bathroom located in the hallway for elimination needs. She stated the water did not feel hot when she washed her hands in the 200-hall bathroom or when staff gathered her water to bath daily.

On 5/16/2022 at 4:55 p.m., Resident #32 was observed exiting the 200-hall bathroom and voiced no concerns with the hot water burning when she washed her hands. The Maintenance Director accompanied the Assistant Maintenance Director to recheck the 200-hall bathroom sink hot water temperature, and it registered 121.7 degrees Fahrenheit. The Maintenance Director stated the mixing valve had been adjusted, the facility had called a plumber, and temperatures would be monitored throughout the evening.

On 5/17/2022 at 2:34 p.m. the Maintenance Director stated the plumber had found rings in the

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F 689	Continued From page 61 mixing valve flattened and broken. The Director stated the mixing valve was repaired but water may require 24 hours to reach even temperatures, and the temperatures were being monitored. On 5/18/2022 at 8:59 a.m., the Assistant Maintenance Director checked the 200-hallway bathroom hot water temperature. The hot water temperature registered 108.6 degrees Fahrenheit. On 5/19/2022 at 4:38 p.m. in an interview with the Administrator with the Maintenance Director present, the Administrator stated hot water temperature were to be within regulatory normal range. The Maintenance Director stated the normal range for hot water temperature was 105 to 115 degrees Fahrenheit.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;	F 690		6/21/22

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F 690	Continued From page 62 (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to attach catheter tubing to a secure device to prevent tension and possible injury to the resident for one of one resident reviewed for catheters (Resident #56). Findings included: A review of the medical record revealed Resident #56 was admitted on 5/12/21 with diagnoses including Diabetes Mellitus, chronic kidney disease, and obstructive and reflux neuropathy (kidney damage from backflow of urine into the kidney.) The annual Minimum Data Set (MDS) dated 3/2/22 noted Resident #56 was cognitively intact and needed extensive to total assistance for all daily care with the help of one to two persons.	F 690	F690 1. Resident #56 was discharged. 2. All residents have the potential to be affected. In house review of the current resident population with catheters to ensure catheter tubing is attached to a secure device to prevent tension and possible injury to the resident. Catheter leg straps provided and secured for identified residents by June 14, 2022. Staff Development Coordinator provided education to licensed nurses and certified nursing assistants on the Indwelling Catheter policy with a focus on ensuring the leg strap securement is secure and the indwelling catheter is attached for all residents with indwelling catheters by	

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F 690	Continued From page 63 The MDS noted an indwelling urinary catheter. The care plan dated 4/19/22 indicated a focus of an indwelling urinary catheter, and the interventions included: Use a catheter strap and document refusal. On 5/15/22 at 4:04 PM Resident #56 was in bed. His catheter bag was covered, and urine was draining. The Nursing Assistant (NA) #14 removed the bed cover, with Resident #56's permission, and there was a securing device attached to Resident #56's leg, but the catheter tubing was not attached. The NA stated it was supposed to be attached and she would tell the nurse. On 5/17/22 at 5:30 PM, the NA #14 again removed the cover to view the securing device. The catheter tubing was attached to the securing device. In an interview with the facility Administrator on 5/19/22 at 4:15 PM, the Administrator stated the tubing was supposed to the attached and secure.	F 690	June 20, 2022. Newly admitted residents with indwelling catheters will be reviewed to ensure a catheter is secured with the indwelling catheter attached. This education will be included in new hire orientation for all licensed nurses and nursing assistants. 3. Ongoing audits to include resident observations will be completed by DON, SDC, and/or Unit Manager to validate the residents with indwelling catheters have a securement device in place and the indwelling catheter is attached to the securement device. These audits will be completed 5 x weekly x 1 week, weekly x 1, and monthly x 3 months. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the DON or ADON. Any issues or trends identified will be addressed by the QAPI committee as they arise, and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, ADON, SDC, MDS Coordinator, Admissions Coordinator, Rehabilitation Manager, Medical Director, and Director of Social Services. Other members may be assigned as the need should arise. 4. The Administrator and Director of Nursing is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by June 21, 2022.	
F 692 SS=D	Nutrition/Hydration Status Maintenance	F 692		6/21/22

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F 692	Continued From page 64 CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review, resident, staff, and Registered Dietician interview the facility failed to address Registered Dietician recommendations for 1 of 1 resident (Resident #68) reviewed for dietary needs. Findings included: Resident #68 was admitted to the facility on 3/23/18 with multiple diagnoses that included diabetes and dementia. Review of Resident #68's medical record revealed a weight of 188.3 on 3/1/22 and a weight	F 692	F692 1.Dietary recommendation for Resident #68 has been addressed. 2.All residents have the potential to be affected. Dietary recommendations reviewed for all in house residents since May 2022. Dietary recommendations not addressed will be executed for all identified residents by June 20, 2022. Regional Dietary Manager provided education to the Registered Dietician on May 19, 2022. This education included	

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F 692	Continued From page 65 of 178.8 on 4/7/22. The most recent Minimum Data Set (MDS) assessment, a quarterly dated 5/9/22 revealed Resident #68 was cognitively intact. A registered dietician progress note dated 5/10/22 recommended adding health shakes three times daily with meals to help halt weight loss. Record review revealed no order for health shakes. During an observation on 5/15/22 at 1:05 PM there was no health shake on Resident #68's tray. An observation on 5/17/22 at 8:33 AM revealed no health shake on Resident #68's breakfast tray. During an interview with the Director of Nursing (DON) on 5/17/22 at 9:07 AM she stated when the registered dietician made recommendations for a resident, they were emailed to her and the Staff Development Coordinator. She reported the resident's responsible party and the physician are notified. She reported the order was then processed. An interview was conducted with the Registered Dietician (RD) on 5/17/22 at 2:01 PM who stated when she has recommendations, she sends an email to the DON and the Staff Development Coordinator. She reported the DON placed the order and contacted the physician. The RD stated she was not aware her recommendation was not followed. No further weights had been obtained for Resident #68.	F 692	providing the Administrator, DON, and Dietary Manager with a hard copy of recommendations and the completion of an exit conference at every facility visit. Staff Development Coordinator provided additional education to the Director of Nursing and Unit Manager on timely execution of dietary recommendations once received from RD by June 20, 2022. This education will be included in new hire orientation for DONs and Unit Managers. 3.Ongoing audits via observation and record reviews will be completed by DON, and/or Unit Managers to validate timely execution of dietary recommendations. These audits will be completed during the Clinical Morning Meeting. Audits will be conducted 2 x weekly x 4 weeks, and then monthly x 3 months. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the DON or Assistant Director Of Nursing. Any issues or trends identified will be addressed by the QAPI committee as they arise, and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, ADON, SDC, MDS Coordinator, Admissions Coordinator, Rehabilitation Manager, Medical Director, and Director of Social Services. Other members may be assigned as the need should arise. 4. The Administrator and Director of Nursing is responsible for implementing and maintaining the acceptable plan of	

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F 692	Continued From page 66 An interview was conducted with the DON on 5/17/22 at 4:35 PM who stated she was unaware of an order for health shakes for Resident #68. After checking her email, she located the Registered Dietician's email discussing Resident #68 which was dated 5/10/22. During an interview with the Staff Development Coordinator on 5/17/22 at 4:40 PM she reported she was not in the facility the day the email was sent and did not recall the email. After checking her email, she located the Registered Dietician's email dated 5/10/22 discussing Resident #68. During an interview with the Administrator on 5/18/22 at 11:30 AM he stated it was his expectation staff members follow up on recommendations from the Registered Dietiican.	F 692	correction. Corrective action to be completed by June 21, 2022.	
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with	F 725		6/21/22

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F 725	Continued From page 67 resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interviews the facility failed to provide sufficient staffing to assist with Activities of Daily Living (ADL) care for residents (Resident #53, #17, #46, #52 and #270) who were dependent on facility staff for ADL care. This affected 5 of 8 residents reviewed for staffing. Findings included: This citation is cross referenced to: F677 Based on record review, observations, staff and resident interviews the facility failed to provide Activities of Daily Living (ADL) care to dependent residents. This occurred for 5 of 8 residents (Resident #53, #17, #46, #52 and #270) reviewed for ADL care. Review of the daily staffing sheets for January 2022 revealed on 1-2-22 there were 4 Nursing Assistants (NA) scheduled for the 3:00pm to 11:00pm shift for approximately 78 residents. On 1-4-22 documentation showed 1 NA at 7:00am until 8:00am when the staffing sheet showed 2	F 725	F725 1. Activities of Daily Living (ADL) care has been provided for Resident #53, #17, #46, and #52. Resident #270 has been discharged. 2. All residents have the potential to be affected. The facility will utilize staffing agencies and continues to recruit nurses to provide sufficient staffing to assist with ADL care for dependent residents. Nursing staffing will be reviewed daily at the morning meeting, by the CEO, DON and facility centralized scheduler to include days, nights and weekends. Education provided to licensed nurses completed by 6/20/22 to contact the Administrative Nurse On Call if they're not able to meet the needs of the residents due to staffing. 3. DON, Administrator, and facility scheduler will continue to review staffing schedules M-F during the morning staffing meeting to ensure sufficient staffing. The Administrator and/ DON will interview five	

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F 725	Continued From page 68 more NAs totaling 3 NAs for the 7:00am to 3:00pm shift for approximately 78 residents and on 1-18-22 the daily staffing sheet revealed 4 NAs were scheduled for the 7:00am to 3:00pm for approximately 73 residents. The facility's daily staffing sheet for 4-26-22 was reviewed and showed 4 NAs were scheduled for the 7:00am to 3:00pm shift for approximately 76 residents. A phone interview was conducted on 5-20-22 at 2:54pm with the facility's scheduler. The scheduler stated there were days when there were only 3-4 NAs scheduled for the entire facility. She stated she would attempt to find help from the agencies and facility staff but somedays there was not any help available. During an interview with the Administrator on 5-19-22 at 5:35pm, the Administrator stated he was unaware there were days when there were only 3-4 NAs working in the building. He also said that could have affected the residents receiving ADL care.	F 725	random staff and interview/observe five residents to validate ADL care has been provided 5x a week for two weeks, twice weekly for two weeks, weekly for two weeks and monthly for three months to ensure sufficient staffing to safely meet the needs of our residents. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Administrator. Any issues or trends identified will be addressed by the QAPI committee as they arise, and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, Staff Development Coordinator, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise. 4. The Administrator and the Director of Nursing is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by June 21, 2022.	
F 726 SS=J	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial	F 726		6/21/22

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F 726	Continued From page 69 well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and Physician interview, the facility failed to train and orient new agency nursing staff and verify competency to deliver care in accordance with the resident's assessed care needs. Nursing Assistant (NA) #1 was not oriented to the protocol for determining residents' dietary orders resulting in the NA feeding a regular textured meal on 5-11-22 to a resident (Resident #369) who had enteral feedings (nutrition delivered by a tube into the digestive system as a liquid) and a physician's order to be nothing by mouth (NPO). Resident #369 aspirated and was hospitalized for 5 days.	F 726	F726 1. Nurse Aide #1 was provided agency orientation immediately after the incident by the Staff Development Coordinator. Nurse Aide #1 no longer works at the facility. 2. All residents have the potential to be affected. The staffing agencies have been provided a copy of the agency orientation guide on 5/12/22. Education provided on the Agency Orientation	

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F 726	Continued From page 70 NA #1 also provided a regular textured meal tray to another resident (Resident #61) who had enteral feedings and a physician's order to be NPO creating a high likelihood of serious harm. This occurred for 2 of 2 residents (Resident #369 and Resident #61) reviewed for enteral feedings. Immediate Jeopardy for example #1 began on 5-11-22 when NA #1 fed Resident #369, who was NPO and on enteral feedings, a regular textured meal. Immediate Jeopardy for example #2 began on 5-11-22 when NA #1 provided Resident #61, who was NPO and on enteral feedings, a regular textured meal. Immediate Jeopardy was removed on 5-19-22 when the facility provided and implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of a "D" (no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy) to complete education and ensure monitoring systems put into place are effective. Findings included: a. Resident #369 was admitted to the facility on 9-22-17 with multiple diagnoses that included gastrostomy status The quarterly Minimum Data Set (MDS) dated 4-13-22 revealed Resident #369 was severely cognitively impaired and required total assistance with one person for feeding. The MDS also coded Resident #369 as receiving 51% or more of her calories from tube feeding and 501 cubic centimeters (cc) or more water per day. The May 2022 active physician's orders included an order for Resident #369 to be NPO and to	F 726	Checklist was provided to all staff including the agency staff which includes nursing processes as well as emergency preparation was provided to agency staff by 5/18/2022 by the Director of Nursing and the Unit Managers. Additionally, new agency staff will receive access to the facility's electronic medical prior to the first day working in the facility and providing resident care. Any staff, to include agency staff, who were not educated by 5/18/2022 will receive education prior to working. This education has been included in orientation for all staff including agency staff. 3. Ongoing audits will be completed via interviews and review of the Agency Orientation binders to validate agency staff in the facility have completed the Agency Orientation Guide prior to working an assignment in the facility. Additional audits via staff interviews will be conducted to validate staff have access to the facility's electronic medical record. These audits will be conducted 5 x weekly x 2 weeks, weekly x 2 weeks, and monthly x 3 months. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the DON or Assistant Director Of Nursing. Any issues or trends identified will be addressed by the QAPI committee as they arise, and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, ADON, SDC, MDS Coordinator, Admissions Coordinator, Rehabilitation	

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F 726	Continued From page 71 receive a fortified nutritional supplement at 55cc per hour continuously through enteral feedings. Resident #369's active care plan as of 5-10-22 revealed a goal that she would remain free of complications related to the use of a feeding tube. The interventions for the goal were in part keep head of the bed elevated, observe for abdominal distention, lung sounds and check for residual. Resident #369 had a second goal that her weight would remain stable. The interventions for the goal were in part resident is NPO, diet as ordered- fortified nutritional supplement and water flushes per order. A nursing progress note dated 5-11-22 at 9:15am by Nurse #2 documented she was called into Resident #369's room by the Wound Care (WC) nurse. Nurse #2 documented she observed the resident with her eyes open, alert to tactile (physical touch) stimuli and coughing up blood-tinged fluid. The documentation indicated the Physician and family members were notified that Resident #369 was being sent to the emergency room for evaluation. The emergency room hospital records dated 5-11-22 revealed a diagnosis of aspiration of food. A CT scan (series of x-ray images) was ordered which showed Resident #369 also had pneumatosis (increased gastric pressure in the colon due to vomiting) along the right colon. The hospital records dated 5-16-22 indicated Resident #369 received intravenous fluids, intravenous antibiotics and was restarted on her enteral feedings. The resident was discharged back to the facility on 5-16-22.	F 726	Manager, Medical Director, and Director of Social Services. Other members may be assigned as the need should arise. 4. The Administrator and Director of Nursing is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by June 21, 2022.	

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b. Resident #61 was admitted to the facility on 7-6-11 with multiple diagnoses that included gastrostomy status.

The May 2022 active physician's orders indicated Resident #61 was to be NPO and was to receive a fortified nutritional supplement at 45 cubic centimeter (cc) per hour continuously through enteral feedings.

The quarterly Minimum Data Set (MDS) dated 5-9-22 revealed Resident #61 was severely cognitively impaired and required total assistance with one person for eating. Resident #61 was also coded for tube feeding acquiring 51% or more of her calories per day with 501cc or more of water per day.

Resident #61's active care plan as of 5-10-22 revealed a goal that she would not exhibit overt signs and symptoms of complications related to her feeding tube. The interventions for the goal were in part administer feedings as ordered, resident is NPO and elevate the head of the bed 30-35 degrees while feeding.

During a phone interview with NA #1 on 5-17-22 at 1:31pm, the NA explained 5-11-22 was her first day working at the facility. She added that it was only her 2nd time working in a long-term care facility. She discussed handing out breakfast trays on 5-11-22 and realizing Resident #369 and Resident #61 had not received a meal tray. NA #1 stated she went to the kitchen and requested 2 meal trays (one for Resident #369 and one for Resident #61) from dietary staff. She said the dietary staff provided her 2 regular textured meal trays with eggs, French toast with apples, sausage patty and orange juice. NA #1 stated she

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went back to the unit, placed Resident #61's tray on the tray table and proceeded to Resident #369 where she began to feed Resident #369 some of the eggs and orange juice. She stated Resident #369 began to turn red in the face and had trouble breathing, so she turned the resident on her side and retrieved help from a nurse that was in a meeting. She explained she did not see any nurses on the unit and had left the resident for approximately 1 minute to get help. NA #1 said she had received no orientation, training or computer access prior starting her shift. She stated she saw the enteral feeding pump for Resident #369 but did not know what it was and since she did not have access to the computer to check the resident's diet, she was unaware the resident was NPO. She added that she did not feed Resident #61 but said another staff member could have tried to feed the resident since she left the meal tray in the resident's room.

The Director of Nursing (DON) was interviewed on 5-17-22 at 2:25pm. The DON stated she was not aware if NA #1 had received training/orientation prior to accepting her work assignment. The DON explained the Staff Development Coordinator would have provided the education.

During an interview with the Staff Development Coordinator (SDC) on 5-18-22 at 9:56am, the SDC confirmed she was responsible for the orientation/training of NA #1 on her first day working at the facility (5-11-22). The SDC revealed she had not provided NA #1 any education/orientation or computer access until after the incident with Resident #369. She explained NA #1 started her shift at 7:00am on 5-11-22 and she did not arrive to work until later

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and she did not want to pull NA #1 off the floor to provide the orientation/education and computer access. The SDC stated she was unaware NA #1 did not have long term care experience. She indicated NA #1 would not have been able to know what her assigned residents' diet orders were or what their care needs were without having orientation. The SDC also discussed new agency staff scheduled off hours and weekends did not receive training/orientation prior to starting their assignment. She added she was concerned for the residents' well-being but did not know how to correct the problem. She also said this was only a problem for agency staff as facility staff received scheduled orientation prior to beginning their first shift.

The Medical Director was interviewed by telephone on 5-19-22 at 3:35pm. The Medical Director stated she was not involved in the training or orientation of staff but expected staff to have the education to care for the residents in the facility.

The Administrator was interviewed on 5-19-22 at 5:35pm. The Administrator stated he expected all staff to be educated and oriented in the care needs of the residents.

The Administrator was notified of Immediate Jeopardy on 5-18-22 at 12:56pm.

Resident #369's diet order: NPO
Resident #61's diet order: NPO

On 5/11/2022 during breakfast meal tray delivery Nurse Aide #1 recognized that Residents #369 and #61 had not received meal trays. She went to the kitchen and requested meal trays for both

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residents and was provided trays with regular textured meals from the Dietary Assistant Manager. At approximately 8:40 am, Nurse Aide #1 delivered a breakfast tray to Resident #369's room.

Nurse Aide #1 sat down to feed Resident #369. Shortly thereafter, resident appeared to have some difficulty and Nurse Aide #1 gave her orange juice. Resident's color appeared red. Nurse Aide #1 turned resident on her side and called out for nursing assistance. Arriving nurse reported resident began to vomit bloody emesis (vomit). Staff called MD and 911 and the resident was sent to the hospital at approximately 9:40 am, while alert and oriented, for further evaluation and treatment. At no time did Resident #369 stop breathing or lose consciousness during event.

Resident #61 was provided a meal tray. Resident #61 was not fed, and the meal tray was left on the bedside table. The meal tray was not accessible to Resident #61. The meal tray was removed from Resident #61's room as soon as staff were aware Nurse Aide #1 had placed a tray in the room.

Upon review of this event, administrative staff immediately implemented the process of dietary staff not issuing a food tray without the resident name being listed on the census diet report audit sheet to prevent a serious adverse outcome from occurring or recurring. Additionally, dietary staff are to consult with the dietary manager and/or the licensed nurse if additional diet clarification is needed. The licensed nurse will validate the correct diet by using the electronic medical record. The dietary manager will validate the correct diet by using the electronic meal tracking

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system.

Post event:
1) Medical director notified, and in-depth ad hoc Quality Assurance & Performance Improvement (QAPI) meeting for this event held 5/11/2022, with the Interdisciplinary Team, Medical Director and Regional Nurse Consultant. The QAPI committee consists of the Administrator, the Medical Director, Director of Nursing (DON), Staff Development Coordinator (SDC), Special Projects DON, Interim Unit Manager, and Regional Nurse Consultant.
2) Plan developed. Root cause was determined to be the following: Nurse Aide #1's first day working at the facility was 5/11/2022 and she received no orientation or training prior to working on the floor. She had no long-term care experience and the failure to orient prior to working on the floor contributed to the deficiency. In addition, the facility failed to validate Nurse Aide #1's access to the electronic medical record. She had no access to the physician's orders or care plans to see what the diet orders were. Nurse Aide #1 failed to validate residents' diet with charge nurse prior to requesting a meal tray from dietary. The Dietary Assistant Manager failed to follow the policy to validate the tray card system, and to consult with the dietary manager and/or a licensed nurse to determine if there was a change in the residents' diet order prior to fixing a meal tray for two residents (Residents #369 and #61).
3) Nurse Aide #1 was provided agency orientation immediately after the incident by the Staff Development Coordinator.
4) Nurse Aide #1 no longer works at the facility. Nurse Aide #1's last day was 5/11/2022. Nurse Aide #1 did not return to the floor after the

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incident.
5) This event was submitted to the state as a reportable on 5/11/2022. The allegation of neglect was substantiated, and the final investigative summary was submitted on 5/18/2022.

All residents are at risk for the current deficient practice.

Plan developed:
1) The facility has provided the staffing agencies a copy of the agency orientation guide on 5/12/22. Agency staff will present to the facility with a signed orientation packet. Agency staff will not be permitted to work until this agency orientation material has been completed. The number to the on-call phone has been posted at each nurse's station for agency staff to receive this education over the phone and complete agency orientation guides have been placed at each nurse's station for reference. A Clinical Team Member rotation, consisting of either the Director of Nursing, Wound Care Nurse, or Staff Development Coordinator, will have the on-call phone on off hours and weekends and will be available to staff to conduct training and other assistance as needed. Should the agency staff arrive to the facility without the orientation packet completed, the agency staff will be directed to contact the on-call phone/Clinical team member for the orientation process to be completed prior to beginning their assignment. The on-call clinical team member will be responsible to be in the facility at the beginning of day shift and available on off hours and will be responsible to collect the agency staff orientation paperwork at the start of the shift or assist with the orientation process. In the afternoon hours of weekend days, approximately 2:45 pm - 7:00 pm, the

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Manager on Duty will be responsible to collect the agency staff orientation paperwork at the start of the afternoon shift, as previously established, or assist the agency staff in contacting the on-call clinical team member to complete the orientation process. The Clinical Team will be responsible to review the schedule daily, specifically on the weekend days, to determine who will be an agency staff person working at the facility for the first time and who will need to have validation of the orientation packet being completed prior to their arrival, or if it must be done on site prior to beginning their job duties. Education will also include information on residents who are NPO and/or fed by a tube. Additional education was provided by the Director of Nurses and Unit Manager for the nursing staff, going over the list of residents who are NPO, and adding list to the CNA care guide notebook located at each nurse's station. Centralized scheduling has been educated by Clinical Information Technology Nurse Technologist on providing agency staff access to the electronic medical record prior to arrival to the facility. If the access is not obtained prior to arrival, the agency staff will call the on-call phone number and access will be provided along with steps to access the system. Validation will be completed that electronic medical record access is successful prior to the staff working their shift. The on- call clinical team member or weekend manager will be responsible for the EMR access validation as stated above for the agency orientation process. This was implemented on 5/18/2022. Any staff, to include agency staff, who were not educated by 5/18/2022 will receive education prior to working on the floor.

2) Facility Staff Development Coordinator, Wound Nurse and/or Regional Nurse Consultant will

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ensure all staff have access to the electronic medical records system prior to the beginning of their first assigned work shift as of 5/16/2022. The on- call clinical team member or weekend manager will be responsible for the EMR access validation as stated above for the agency orientation process. No nursing staff will work on the floor after 5/16/2022 without access to the electronic medical records system. Orientation on the electronic medical record will be completed with the agency staff by the facility wound nurse, staff development coordinator, and/or the regional nurse consultant. The Agency Orientation Checklist includes education on how to use the medical records system. In addition, the Clinical Team Member or Weekend Manager are responsible to audit agency staff and validating staff are accessing the electronic medical record for resident care needs. The agency staff are also instructed on the use of the care delivery guides for information on each resident's care needs prior to working on the floor.

3) The Agency Orientation Checklist has been reviewed by the Regional Nurse Consultant on 5/18/22 and approved for education purposes for agency staff and is designed to be completed at the start of the shift for new agency staff. The orientation checklist covers nursing processes, as well as emergency preparation for newcomers to the facility.

4) Additional education provided by the Director of Nursing and Unit Manager on the CNA care guide located at each nurse's station which contains resident diet orders. Any staff, to include agency staff, who were not educated by 5/18/2022 will receive education prior to working on the floor.

5) Agency orientation guides have been placed at

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each nurse's station as an additional resource. The guides were placed at the nurses on 5/17/2022. The staff have been re-educated by the Regional Nurse Consultant and Director of Nurse on the placement of the agency orientation guides at each nurses' station as an accessible resource. Any staff, to include agency staff, who were not educated by 5/18/2022 will receive education prior to working on the floor.
6) Agency staff will be educated on the CNA care report cards located at each nurse's station to include the residents' current diet orders and the definition of NPO (nothing by mouth) by the Director of Nursing, Staff Development Coordinator, and the Regional Nurse Consultant beginning 5/17/2022. No staff including agency staff will work on the floor after 5/17/2022 until education has been received.
7) Staff were provided education on the severity of what could happen to a resident if they were provided a diet that was not ordered by the physician and could result in serious adverse outcomes by the Director of Nursing and the Staff Development Coordinator. No staff including agency staff will work on the floor after 5/17/2022 until education has been received.

Alleged date of IJ removal: 5/19/2022.

The facility's credible allegation of Immediate Jeopardy was validated onsite on 5-24-22 through interviews with facility staff including nursing staff as well as the Regional Consultant. The staff verbalized receipt of education prior to starting their shift in the facility. The staff education documentation, audits and monitoring were reviewed. Nursing staff education included completing the orientation checklist and obtaining access to the facility's electronic medical records

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F 726	Continued From page 81 system prior to providing resident care, and the use of the resident care guides to locate resident care information including diets. Nurse aides were observed using resident care guides, located at the nursing station, to confirm resident's diets and stated resident diets were verified with nursing staff before requesting a diet tray from the kitchen. Meal audits indicated no issues with residents receiving the correct diets. Signage with contact information was posted at the time clock and both nursing stations reminding nursing staff not to provide resident care until obtaining access to the facility's electronic medical record system and receiving the Orientation Checklist. Interviews with the nursing staff and a review of staffing audits revealed new agency staff were receiving access to the facility's electronic medical records and the orientation checklist information prior to or on the first day working in the facility and providing resident care. The facility's date of immediate jeopardy removal of 5-19-22 was validated.	F 726		
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.	F 727		6/21/22

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F 727	Continued From page 82 §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to schedule a Registered Nurse (RN) for at least 8 consecutive hours a day for 12 of 60 days (10-31-21, 10-30-21, 10-24-21, 10-23-21, 12-19-21, 12-18-21, 1-2-22, 1-1-22, 4-17-22, 5-15-22, 5-8-22 and 5-7-22) reviewed for staffing. Findings included: Review of the facility's daily staffing sheets revealed there was not an RN scheduled for at least 8 consecutive hours on the following dates: 10-31-21, 10-30-21, 10-24-21, 10-23-21, 12-19-21, 12-18-21, 1-2-22, 1-1-22, 4-17-22, 5-15-22, 5-8-22 and 5-7-22. A phone interview occurred with the centralized scheduling supervisor on 5-20-22 at 9:02am. The supervisor explained the facility switched to centralized scheduling 4-25-22 and she did not have access to any schedules prior to 4-25-22. She discussed on 5-7-22, 5-8-22 and 5-15-22 there was a RN scheduled for 8 hours but had only worked 7.5 hours each day. During a phone interview with the facility's scheduler on 5-20-22 at 9:50am, the scheduler confirmed she would have been the one to schedule an RN on 10-31-21, 10-30-21, 10-24-21, 10-23-21, 12-19-21, 12-18-21, 1-2-22, 1-1-22, and 4-17-22. She stated some days she could not find an RN to work, and she said she was unaware the RN had to work 8 consecutive	F 727	F727 1. The facility has scheduled a Registered Nurse (RN) for at least 8 consecutive hours a day. 2. All residents have the potential to be affected. Nursing staffing will be reviewed daily during the morning staffing meeting, by the CEO, DON and facility centralized scheduler to include days, nights and weekends to validate a RN is scheduled for 8 consecutive hours each day. Education provided to the centralized scheduler to contact the administrator and DON if she is unable to schedule a RN for 8 consecutive hours each day. This education was provided by the Director of Nursing (DON) by June 20, 2022. This education will be included in new hire orientation for facility schedulers. 3. Ongoing auditing will be completed to validate the provision of a RN for at least 8 consecutive hours a day. Audits will be completed 5 x weekly for two weeks, weekly x 2 weeks, and monthly x 3 month by the Administrator and/or the Director of Nursing. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Administrator. Any issues or trends identified will be addressed by the QAPI committee as they arise, and	

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F 727	Continued From page 83 hours. The Administrator was interviewed on 5-19-22 at 5:35pm. The Administrator stated the facility had difficulty getting RN's to work but stated he was unaware there had not been an RN scheduled a full 8 hours.	F 727	the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, Staff Development Coordinator, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise. 4. The Administrator and the Director of Nursing is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by June 21, 2022.	
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or	F 757		6/21/22

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F 757	Continued From page 84 §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to address a recommendation from an outside consultant for 1 of 6 residents reviewed for unnecessary medications (Resident #269). The findings included: Resident #269 was admitted to the facility on 2/17/22 with diagnoses that included a cerebral infarction (stroke). He discharged on 4/18/22. Review of physician orders revealed an order dated 2/17/22 for Amantadine (a medication to treat movement disorders) 10 milliliters by mouth twice a day. A progress note from neurology dated 3/3/22 read in part "Amantadine was started presumably for day time alertness. Given the patient no longer has this concern and is having difficulty sleeping at night will stop Amantadine." Review of Medication Administration record for March 2022 and April 2022 revealed Amantadine was administered twice daily until discharge. An interview was conducted with Resident #269 s family member on 5/16/22 at 1:26 PM who stated she met Resident #269 at his neurologist appointment on 3/3/22 and was aware his Amantadine was discontinued. She reported she realized it had been continued when she was reviewing his discharge medications.	F 757	F757 1. Resident #269 has been discharged. 2. All residents have the potential to be affected. In house review to be completed on current resident population to validate that each residents□ medication regimen is free from unnecessary medications and physician orders are followed. Physician orders from resident appointments will be reviewed for each resident from May 2022 going forward to validate implementation of physician orders. Outstanding physician orders will be implemented for the identified residents by June 20, 2022. Education on unnecessary medications and the importance of following physician orders will be provided for licensed nurses by the Staff Development Coordinator by June 20, 2022. This training will also be included in new hire orientation for licensed nurses. 3. Ongoing audits will be completed by the Director of Nursing, SDC, and/or Unit Manager for review of new orders/ pharmacy recommendations during the Clinical Whiteboard and weekly At Risk Meeting. These audits will be conducted 5 days per week for two weeks, then weekly for two weeks, then monthly for three months. All data will be summarized and presented to the facility Quality Assurance	

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F 757	Continued From page 85 An interview was conducted with the Medical Records Director on 5/18/22 at 11:49 AM who stated she is responsible for ensuring consult reports from outside appointments are received. She reported she did not receive a consult report after Resident #269 ' s neurology appointment on 3/3/22. She stated she has had difficulty receiving reports after appointments with the provider. During an interview with the Director of Nursing on 5/18/22 at 3:08 PM who stated Medical Records was responsible for getting the information from any outside appointments. She reported that she was unaware of any issues with getting consult reports. The DON stated had she been aware that Resident #269's neurologist had discontinued a medication it would have been addressed.	F 757	and Performance Improvement meeting monthly by the DON or ADON. Any issues or trends identified will be addressed by the QAPI committee as they arise, and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, ADON, SDC, MDS Coordinator, Admissions Coordinator, Rehabilitation Manager, Medical Director, and Director of Social Services. Other members may be assigned as the need should arise. 4. The Administrator and Director of Nursing are responsible for maintaining compliance. Compliance achieved by June 21, 2022.	
F 802 SS=J	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	F 802		6/21/22

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F 802	Continued From page 86 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 record review and staff interviews the facility failed ensure that dietary staff were competent to carry out the functions of the food and nutrition service in accordance with residents' dietary orders. The Dietary Assistant Manager provided Nursing Assistant (NA) #1 with a regular textured meal for 2 residents (Resident #369 and #61) who were ordered nothing by mouth (NPO) and on enteral feedings (nutrition delivered by a tube into the digestive system as a liquid) continuously resulting in Resident #369 aspirating and being hospitalized. Immediate Jeopardy began on 5-11-22 when the Dietary Assistant Manager provided regular meal trays for 2 residents (Resident #369 and Resident #61) who were NPO and on continuous enteral feedings. The Immediate jeopardy was removed on 5-19-22 when the facility provided and implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope/severity of a "D" (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective related to competent dietary staff. Findings included: a. The May 2022 active physician's orders included an order for Resident #369 to be NPO and to receive a fortified nutritional supplement at 55 cubic centimeter (cc) per hour continuously	F 802	1. The assistant dietary manager is no longer employed at the facility. 2. All residents have the potential to be affected. Education provided to dietary staff that providing a diet not ordered for a resident could result in serious adverse outcomes. This education was provided by the Director of Nursing and the Regional Dietary Manager on 5/18/22. No dietary staff will work after 5/18/2022 until education has been completed. This education will be included in new hire orientation for all dietary staff. 3. Ongoing audits will be completed by the Dietary Manager and/or the Regional Dietary Manager via staff interviews and observations to validate dietary staff understanding of resident diets, textures, and restrictions. Additionally, dietary staff will be able to state the process to follow if they are unsure about a residents' diet. These audits will be completed weekly x 2 weeks and monthly x 3months. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the DON or Assistant Director Of Nursing. Any issues or trends identified will be addressed by the QAPI committee as they arise, and the plan will be revised to ensure continued compliance. The QAPI committee	

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F 802	Continued From page 87 through enteral feedings. b. The May 2022 active physician's orders indicated Resident #61 was to be NPO and was to receive a fortified nutritional supplement at 45 cubic centimeter (cc) per hour continuously through enteral feedings. During a phone interview with NA #1 on 5-17-22 at 1:31pm, the NA discussed handing out breakfast trays on 5-11-22 and realized Resident #369 and Resident # 61 had not received a meal tray. The NA stated she went to the kitchen and requested 2 meal trays for Resident #369 and Resident #61 from dietary staff. She said the dietary staff provided her 2 regular meal trays with eggs, French toast with apples, sausage patty and orange juice and commented the dietary staff had not mentioned to her the residents were NPO. She stated she saw the enteral feeding pump but did not know what it was and since she did not have access to the computer to check the resident's diet, she was unaware the residents were NPO. She added that she did not feed Resident #61 but said another staff member could have tried to feed the resident since she left the meal tray in the resident's room. During the interview, the NA explained on 5-11-22 she fed Resident #369 eggs and orange juice. The NA stated Resident #369 began to turn red in the face and had trouble breathing, so she turned the resident on her side and retrieved help from a nurse that was in a meeting. Resident #369 was sent to the emergency room and hospitalized for 5 days. A telephone interview occurred with the Dietary Assistant Manager on 5-17-22 at 1:56pm. The	F 802	consists of the Administrator, DON, ADON, SDC, MDS Coordinator, Admissions Coordinator, Rehabilitation Manager, Medical Director, and Director of Social Services. Other members may be assigned as the need should arise. 4. The Administrator and Dietary Manager is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by June 21, 2022.	

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Dietary Assistant Manager explained he had been working at the facility for "a few weeks" but had received the new employee training that included the tray card print outs and how to verify orders in the computer. He stated Nursing Assistant (NA) #1 came to the kitchen on 5-11-22 during the breakfast meal and requested meal trays for Resident #369 and Resident #61. He discussed checking the dietary orders in the electronic medical record for both residents and saw they were both NPO and received enteral feedings but thought staff was trying to switch the residents back onto solid food, so he provided a regular meal tray consisting of eggs, French toast with apples, sausage patty and orange juice for both Resident #369 and Resident #61 to the NA. The Dietary Assistant Manager stated he could only see a resident's dietary order in the computer. He explained that sometimes the orders were not entered into the electronic medical record before trays were passed out, so he did not know if there had been an actual order to switch the residents back onto solid foods and should have asked the Dietary Manager or the nursing staff before providing the trays.

The Dietary Manager (DM) was interviewed on 5-19-22 at 11:47am. The DM explained he was not in the kitchen when NA #1 requested 2 meal trays for Resident #369 and Resident #61 on 5-11-22. He stated the Dietary Assistant Manager was a new employee but received new employee training/orientation on the tray card print outs and how to verify diet orders in the computer. He said the Dietary Assistant Manager should have found him or clarified the order with the nurse prior to giving the trays to the NA.

The Administrator was interviewed on 5-19-22 at

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5:35pm. The Administrator stated he expected dietary staff to follow dietary orders and seek clarification from management if there are any questions before providing a meal tray to any resident.

The Administrator was notified of Immediate Jeopardy on 5-18-22 at 1:55pm.

Resident #369's diet order: NPO
Resident #61's diet order: NPO

On 5/11/2022 during breakfast meal tray delivery Nurse Aide #1 recognized that Residents #369 and #61 had not received meal trays. She went to the kitchen and requested meal trays for both residents and was provided trays with regular textured meals from the Dietary Assistant Manager. At approximately 8:40 am, Nurse Aide #1 delivered a breakfast tray to Resident #369's room.

Nurse Aide #1 sat down to feed Resident #369. Shortly thereafter, resident appeared to have some difficulty and Nurse Aide #1 gave her orange juice. Resident's color appeared red. Nurse Aide #1 turned resident on her side and called out for nursing assistance. Arriving nurse reported resident began to vomit bloody emesis (vomit). Staff called MD and 911 and the resident was sent to the hospital at approximately 9:40 am, while alert and oriented, for further evaluation and treatment. At no time did Resident #369 stop breathing or lose consciousness during event.

Resident #61 was provided a meal tray. Resident #61 was not fed, and the meal tray was left on the bedside table. The meal tray was not accessible to Resident #61. The meal tray was removed

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from Resident #61's room as soon as staff were aware Nurse Aide #1 had placed a tray in the room.

Post event:
- Medical director notified, and in-depth ad hoc Quality Assurance & Performance Improvement (QAPI) meeting for this event held 5/11/2022, with the Interdisciplinary Team, Medical Director and Regional Nurse Consultant. The QAPI committee consists of the Administrator, the Medical Director, Director of Nursing (DON), Staff Development Coordinator (SDC), Special Projects DON, Interim Unit Manager, and Regional Nurse Consultant.
- Plan developed. Root cause was determined to be the following: Nurse Aide #1's first day working at the facility was 5/11/2022 and she received no orientation or training prior to working on the floor. She had no long-term care experience and the failure to orient prior to working on the floor contributed to the deficiency. In addition, the facility failed to validate Nurse Aide #1's access to the electronic medical record. She had no access to the physician's orders or care plans to see what the diet orders were. Nurse Aide #1 failed to validate residents' diet with charge nurse prior to requesting a meal tray from dietary. The Dietary Assistant Manager failed to follow the policy to validate the tray card system, and to consult with the dietary manager and/or a licensed nurse to determine if there was a change in the residents' diet order prior to fixing a meal tray for two residents (Residents #369 and #61).
- Dietary Assistant Manager was suspended on 5/11/2022. He remains on suspension, but termination has been recommended on 5/17/2022.
- This event was submitted to the state as a

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reportable on 5/11/2022. This event was submitted to the state as a reportable on 5/11/2022. The allegation of neglect was substantiated, and the final investigative summary was submitted on 5/18/2022.

All residents are at risk for the current deficient practice.

Plan developed:
- Dietary staff educated that providing a diet not ordered for a resident could result in serious adverse outcomes by the Director of Nursing and the Regional Dietary Manager on 5/18/2022. No dietary staff will work after 5/18/2022 until education has been completed.
- Dietary manager reviewed the census diet report (a roster of residents and diet orders) with the dietary staff and re-education provided on the validation process to follow prior to giving out any food/drinks on 5/17/2022. The dietary staff will refer to the census dietary report prior to issuing a meal tray to a resident. No dietary staff will work after 5/18/2022 until education has been completed.
- Dietary manager will provide validation with dietary staff to ensure understanding resident diets, texture, and restrictions. Dietary staff will be able to state the process to follow if they are unsure about a residents' diet. A copy of the facility's dietary provider's "Diet Cross Walk" (dietary conversion list provided a comparable diet or meal plan), and the National Dysphagia diet level and Consistency modified diet control panel will be posted as a dietary staff resource. This validation was started and completed on 5/17/2022. The information was posted on the board in the kitchen for staff review on 5/17/2022. No dietary staff will work after 5/17/2022 until

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validation has been completed.
- Dietary staff will not issue a food tray without the resident name being listed on the census diet report audit sheet. Dietary staff has been educated by the Regional Dietary Manager to consult with the dietary manager and/or the licensed nurse if additional diet clarification is warranted. The licensed nurse will validate the correct diet by using the electronic medical record. The dietary manager will validate the correct diet by using the electronic meal tracking system. This action was completed 5/18/2022.

Alleged date of IJ removal: 5/19/2022.

The facility's credible allegation of Immediate Jeopardy was validated onsite on 5-24-22 through interviews with facility staff including dietary staff. The dietary staff verbalized receipt of education including the importance of providing resident with the correct diet as ordered. The staff education documentation, audits and monitoring were reviewed. All resident diets were audited for accuracy, and daily meal audits indicated no issues with residents receiving the correct diets. Dietary staff education included the use of resident diet list to confirm a resident's diet and to clarify resident diets with the dietary manager or nurse as needed. Dietary staff stated resident dietary list was printed daily and referenced to when nursing staff requested diet trays for residents, and a list of residents with nothing by mouth (NPO) diets, resident diet list, diet terminology conversion list and national dysphagia diet levels were posted in the kitchen to reference for diet information. Daily meal audits indicated no issues with residents receiving the correct diets.

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F 802	Continued From page 93 The facility's date of immediate jeopardy removal of 5-19-22 was validated.	F 802		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to label and date left over food items and discard expired food items available for use in 2 of 2 kitchen refrigerators. This practice had the potential to affect the food served to 58 of 70 residents. Findings included: On 5/15/2022 at 9:30 a.m. the initial tour of the kitchen with Dietary Aide (DA) #1 revealed the following food items not labeled, dated or expired	F 812	F812 1. Leftover food items have been labeled and dated. Expired food items have been discarded. 2. All residents had the potential to be affected. Completed inspection of the kitchen was made by the Registered Dietician to ensure deficient areas remain corrected. This was completed by June 20, 2022. Education on the Food	6/21/22

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F 812	Continued From page 94 in the refrigerators: From the reach-in refrigerator: -Two sandwiches with no label or date. These were discarded by DA #1. - Italian dressing dated open on 3/22/2022 with no manufacturer ' s expiration date on the container was discarded by DA #1. - A storage container ½ full of cooked field peas with no label or date was discarded by DA #1. From the walk-in refrigerator: - A tray of clear bowls with non-sealing cup lids laying on top of tomatoes and peaches with no label or date were discarded by DA #1. - Thawed turkey breast wrapped in plastic wrap with no label or date in a box dated 5/10/2022 was discarded by DA #1. - Thawed turkey breast with a cut in the original package exposing the turkey breast to the air in a box dated 5/10/2022 was discarded by DA #1. - Four large unopened containers of Horseradish with expiration dates 12/29/2021 were discarded by DA #1. - Pears in a storage container dated 5/10/2022 were discarded by DA #1. On 5/15/2022 at 10:15 a.m. in an interview with DA #1, she stated food items were covered, labeled and dated when placed in the kitchen refrigerators, and food items were good for three days from the date placed in the refrigerators or the expiration date. On 5/16/2022 at 5:00 p.m. in an interview with the Administrator, he stated food items in the kitchen refrigerators were to be labeled, dated and	F 812	Procurement/ Storage/ Preparation policy was conducted with the Dietary Staff by June 20, 2022 by the Regional Dietary Manager. This training will also be provided to all Dietary Staff upon hire during orientation. 3. Ongoing audits by the Administrator, Registered Dietician and Dietary Manager will be conducted for observation and review to the facility is storing, preparing, distributing and serving food in accordance with professional standards for food service safety. These audits will be conducted 5 x weekly for two weeks, weekly for two weeks and monthly for three months. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Administrator. Any issues or trends identified will be addressed by the QAPI committee as they arise, and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, Staff Development Coordinator, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise. 4. The Administrator and the Dietary Manager is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by June 21, 2022.	

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SIGNATURE HEALTHCARE OF KINSTON	907 CUNNINGHAM ROAD KINSTON, NC 28501

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F 812	Continued From page 95 discarded after expiration. On 5/17/2022 at 4:01 p.m. in an interview with the Dietary Manager, he stated he checked the reach-in and walk-in refrigerators for expired food items daily, and the dietary cook was responsible for checking the refrigerators for food items expired on Saturday and Sunday. He stated opened and prepared food items were to be labeled and dated when placed in refrigerators and expired after seven days or the marked expiration date on the container. On 5/20/2022 at 1:29 p.m. in an interview with Dietary Cook #1, he stated the cook was responsible for checking the date on food items stored in the reach-in and walk-in refrigerators at the beginning of the shift for expired foods. He stated food items were to be covered, labeled and dated when opened or cooked and placed in the refrigerators. He stated he was the cook scheduled on 5/15/2022 and did not recall checking the food items in the refrigerators for expirations and labeling of food items.	F 812		
F 835 SS=J	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide leadership and oversight to ensure effective systems were in place for	F 835	1. Nurse Aide #1 and the Assistant Dietary Manager are no longer employed at the facility.	6/21/22

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F 835	Continued From page 96 training, orienting, and verifying competencies for new agency staff which resulted in Nursing Assistant (NA) #1 providing a regular meal tray to two residents (Resident #369 and Resident #61) who were to receive nothing by mouth (NPO) and received continuous enteral feedings (nutrition delivered by a tube into the digestive system as a liquid). Immediate Jeopardy began on 5-11-22 when the facility failed to ensure NA #1 was trained, oriented and competent to care for residents who were NPO and on enteral feedings. Immediate Jeopardy was removed on 5-19-22 when the facility provided and implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope/severity of an "D" (no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy) to complete education and ensure monitoring systems put into place are effective. Findings included: This tag is cross referenced to: F726 Based on record review, staff interviews, and Physician interview, the facility failed to train and orient new agency nursing staff and verify competency to deliver care in accordance with the resident's assessed care needs. Nursing Assistant (NA) #1 was not oriented to the protocol for determining residents' dietary orders resulting in the NA feeding a regular textured meal on 5-11-22 to a resident (Resident #369) who had enteral feedings (nutrition delivered by a tube into	F 835	2. All residents have the potential to be affected. Administration staff, consisting of the Administrator, Director of Nursing, Staff Development Coordinator, and Regional Nurse Consultant reviewed the facility's protocol for orienting, training, and verifying competencies of new staff prior to allowing staff to work on the floor. Education was provided on 5/18/22 by the Regional Nurse Consultant to the Administrator pertaining to the regulatory requirement that a facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This education will be included in new hire orientation for all administrators. 4. Ongoing audits will be completed by the administrator to validate that residents are receiving diets as order by the physician, agency staff are receiving orientation via the Agency Orientation Guide prior to working a shift, agency staff will have access to the electronic medical record prior to working a shift, and dietary staff will not provide meal trays for residents without validating the correct diet is prepared. These audits will be completed 5 x weekly x 2 weeks, weekly x 2 weeks, and monthly x 3 months. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the DON or Assistant Director Of Nursing. Any issues or trends identified will be	

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F 835	Continued From page 97 the digestive system as a liquid) and a physician's order to be nothing by mouth (NPO). Resident #369 aspirated and was hospitalized for 5 days. NA #1 also provided a regular textured meal tray to another resident (Resident #61) who had enteral feedings and a physician's order to be NPO creating a high likelihood of serious harm. This occurred for 2 of 2 residents (Resident #369 and Resident #61) reviewed for enteral feedings. The Administrator was interviewed on 5-19-22 at 5:35pm. The Administrator discussed it was the Staff Development Coordinators (SDC) position to ensure all agency staff were trained and oriented prior to starting their shift and the Director of Nursing (DON) was to oversee the training and orientation was complete as well as being available for any questions the agency staff may have. The Administrator stated the management in the facility were agency/contract staff which led to a lack of consistency and poor communication. The Administrator was notified of Immediate Jeopardy on 5-18-22 at 2:51pm. Resident #369's diet order: NPO Resident #61's diet order: NPO On 5/11/2022 during breakfast meal tray delivery Nurse Aide #1 recognized that Residents #369 and #61 had not received meal trays. She went to the kitchen and requested meal trays for both residents and was provided trays with regular textured meals from the Dietary Assistant Manager. At approximately 8:40 am, Nurse Aide #1 delivered a breakfast tray to Resident #369's room.	F 835	addressed by the QAPI committee as they arise, and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, ADON, SDC, MDS Coordinator, Admissions Coordinator, Rehabilitation Manager, Medical Director, and Director of Social Services. Other members may be assigned as the need should arise. 4. The Administrator is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by June 21, 2022.	

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Nurse Aide #1 sat down to feed Resident #369. Shortly thereafter, resident appeared to have some difficulty and Nurse Aide #1 gave her orange juice. Resident's color appeared red. Nurse Aide #1 turned resident on her side and called out for nursing assistance. Arriving nurse reported resident began to vomit bloody emesis (vomit). Staff called MD and 911 and the resident was sent to the hospital at approximately 9:40 am, while alert and oriented, for further evaluation and treatment. At no time did Resident #369 stop breathing or lose consciousness during event.

Resident #61 was provided a meal tray. Resident #61 was not fed, and the meal tray was left on the bedside table. The meal tray was not accessible to Resident #61. The meal tray was removed from Resident #61's room as soon as staff were aware Nurse Aide #1 had placed a tray in the room.

Post event:
- Medical director notified, and in-depth ad hoc Quality Assurance & Performance Improvement (QAPI) meeting for this event held 5/11/2022, with the Interdisciplinary Team, Medical Director and Regional Nurse Consultant. The QAPI committee consists of the Administrator, the Medical Director, Director of Nursing (DON), Staff Development Coordinator (SDC), Special Projects DON, Interim Unit Manager, and Regional Nurse Consultant.
- Plan developed. Root cause was determined to be the following: Nurse Aide #1's first day working at the facility was 5/11/2022 and she received no orientation or training prior to working on the floor. She had no long-term care experience and the failure to orient prior to working on the floor contributed to the deficiency. In addition, the

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facility failed to validate Nurse Aide #1's access to the electronic medical record. She had no access to the physician's orders or care plans to see what the diet orders were. Nurse Aide #1 failed to validate residents' diet with charge nurse prior to requesting a meal tray from dietary. The Dietary Assistant Manager failed to follow the policy to validate the tray card system, and to consult with the dietary manager and/or a licensed nurse to determine if there was a change in the residents' diet order prior to fixing a meal tray for two residents (Residents #369 and #61).

All residents are at risk for the current deficient practice.

- Administration staff, consisting of the Administrator, Director of Nursing, Staff Development Director, and Regional Nurse Consultant, immediately reviewed the facility's protocol for orienting, training, and verifying competencies of new staff prior to allowing the staff to work on the floor. Root Cause Analysis review completed and determined staff were not consistent in completing new agency staff orientation at the start of their shift, leaving the potential for significant issues to arise with resident care. Based on this review, it was determined additional oversite was required with completing the first-time agency staff orientation to remove the potential for significant issues with resident care. The administrative team is ultimately responsible to attain and maintain the implementation of the revised plan to ensure orientation is completed and competencies verified at the time of agency staff's initial shift in the building prior to the staff working on the floor. The revised plan was fully implemented on

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5/18/22.
- Education was provided on 5/18/22 by the Regional Nurse Consultant to the administrator reviewing thoroughly F835 at §483.70 Administration from Appendix PP of the State Operations Manual. This education focused on the regulatory requirement that a facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

Alleged date of IJ removal: 5/19/2022.

The facility's credible allegation of immediate jeopardy removal was validated onsite on 5-24-22 through interviews with facility staff including nursing staff and dietary staff as well as the Regional Consultant. The staff verbalized receipt of education prior to starting their shift in the facility. The staff education documentation, audits and monitoring were reviewed. The dietary manager education dated 5/11/2022 included different types of diets, nothing by mouth (NPO) and the importance of the accuracy of resident diets, and these topics were included in the re-education of the dietary staff. Dietary staff education also included use of resident diet list to validate resident's diet and confirmation with dietary manager or nurse as needed. Assistance with meals education conducted on 5/11/2022 to the nursing staff included checking meal tray card for correct resident and diet and verifying physician diet order with nurse. The administrative team education dated 5/18/2022 included administration regulation, ensuring expected practices were followed and overseeing as necessary on the floor to assist staff in resident care. Nursing education also included

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F 835	Continued From page 101 providing resident care before receiving access to the facility's electronic resident record and the orientation checklist information. Staffing audits and interviews revealed centralized scheduling or management staff were providing the orientation checklist and access to the facility's electronic medical record prior to the agency staff reporting to work and prior to providing resident care. Nursing staff were using resident care guides for resident care information including diet orders and were verifying resident diets with the assigned nurse before requesting a diet tray from the kitchen, and dietary staff used the daily printed resident diet list, NPO list, dietary manager and nurse to confirm resident's diet. Daily meal audits indicated residents were receiving diets as ordered. The facility's date of immediate jeopardy removal of 5-19-22 was validated.	F 835		
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,	F 880		6/21/22

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F 880	Continued From page 102	F 880		

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

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

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the

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F 880	Continued From page 103 corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to follow the Centers for Disease and Prevention (CDC) guidelines for personal protective equipment (PPE) for enhanced droplet precautions when Nurse #1 was observed entering Resident #319's room without eye protection and wearing a disposable face mask instead of an N95 mask and failed to remove mask when exiting Resident 319's room and the Transportation Aide was observed exiting Resident #28's room after retrieving a meal tray wearing a disposable face mask instead of an N95 mask also failed to discard the disposable face mask for 2 of 2 staff members observed for infection control practices. This occurred during the COVID-19 pandemic. Findings included: The facility COVID-19 policy updated 3/18/22 stated, "Approved respirators (such as N95 respirators) should be used in accordance with CDC recommendations in appropriate transmission-based precaution settings and requiring eye protection (face shield or goggles) to be worn by Stakeholders (in addition to masks) in resident/patient care areas should be based on	F 880	F880 1. Nurse #1 and the Transportation Aide have been provided education on the Centers for Disease and Prevention (CDC) guidelines for personal protective equipment (PPE) for enhanced droplet precautions by June 20, 2022. 2. All residents had the potential to be affected by the deficient practices. The Auditing being completed by the Staff Development Coordinator of the current resident population requiring enhanced droplet precautions will be to validate proper eye wear and N95 masks are being worn by facility staff. Staff observed without proper PPE will receive on the spot 1:1 educations, progressive disciplinary actions, and subsequent termination of employment. The SDC will provide education to all staff on Infection Control as it pertains to wearing / using the proper PPE when entering and exiting a resident's room requiring enhance droplet precaution by June 20, 2022. This education will be provided in new hire	

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F 880	Continued From page 104 requirements by local and/or state health departments, in accordance with CDC, state and/or federal regulations". Based on the CDC Data Tracker website on 5/15/22, the community transmission level at the time of the survey was moderate. An interview was conducted with the interim Director of Nursing on 5/15/22 at 12:00 PM and she stated there were no staff or resident COVID-19 positive cases at the facility. 1.a. On 5/15/22 at 1:00 PM, Nurse #1 was observed entering Resident #319's room wearing a gown, gloves, disposable face mask, and no eye protection. Signage for enhanced droplet precautions was noted on Resident #319's door and instructed staff to wear gown, gloves, eye protection and an N-95 mask before entering the room. At 1:05 PM on 5/15/22, Nurse #1 was observed exiting Resident #319's room wearing the same face mask. Nurse #1 had removed her gown and gloves before she exited the room and sanitized her hands in the hallway using the wall hand sanitizer. An interview was conducted with Nurse #1 on 5/15/22 at 1:06 PM. When she was asked if she was required to apply a new mask after exiting Resident #319's room on enhanced droplet precautions, she stated she was supposed to get a new mask but felt flustered and forgot. Nurse #1 stated she was supposed to wear eye protection when entering a room on enhanced droplet precaution but she forgot.	F 880	orientation for all staff. 3.Ongoing auditing to include observations of facility staff to validate donning proper PPE when providing care for residents requiring enhanced droplet precaution will be completed by the Director of Nursing and/or SDC. These audits and observations will be conducted 5 days a week for 2 weeks, 2 x weekly for 2 weeks, weekly for 2 weeks and then monthly x 3 months. Any incident of non-compliance with Infection Control guidelines as it relates to failure to don the proper PPE when providing care for residents on enhanced droplet precautions will be addressed as they arise. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Administrator. Any issues or trends identified will be addressed by the QAPI committee as they arise, and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, Staff Development Coordinator, MDS Coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise. 4. The Administrator and Director of Nursing is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by June 21, 2022.	

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F 880	Continued From page 105 b. On 5/18/22 at 1:05 PM, the Transportation Aide was observed exiting Resident #28's room wearing goggles and a disposable face mask carrying a meal tray and placing the meal tray on the food cart located in the hallway. She was observed sanitizing her hands using the wall hand sanitizer in the hallway. The enhanced droplet precaution sign on the door instructed gowns, gloves, eye protection and N-95 mask be worn before entering the room. At the time of the observation the Transportation Aide was asked if she needed to remove her mask and replace with a new mask when exiting an enhanced droplet precaution room and she stated "Yes". She stated she just forgot. An interview was conducted with the interim Infection Control Nurse on 5/19/22 at 2:00 PM and she stated staff entering rooms on enhanced droplet precautions should be wearing a gown, gloves, N95 mask, and eye protection. She stated a new mask should be put on when exiting those rooms. On 5/19/22 at 4:25 PM an interview was conducted with the Administrator, and he stated he expected staff to don and doff PPE per the CDC guidelines.	F 880		