STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345562	A. BUILDING _____ B. WING _____	05/26/2022

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CLEAR CREEK NURSING & REHABILITATION CENTER	10506 CLEAR CREEK COMMERCE DRIVE MINT HILL, NC 28227

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F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted 5/23/2022 to 5/26/2022. Four of the 37 complaint allegations were substantiated. Intakes: NC00186790, NC00187797, NC00171539, NC00174102, NC00188743, NC00181242, NC00187236, NC00175099, NC00186471, NC00176317, NC00179494 were investigated. Event ID # HP7U11.	F 000		
F 584 SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition;	F 584		6/15/22

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

Electronically Signed | 06/18/2022

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F 584	Continued From page 1 §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain wall integrity in the residents' rooms in good repair for 3 of 10 sampled resident rooms 510, 603, and 709. The facility further failed to fix a leaking toilet in 1 of 10 sampled resident room 706. The findings included: 1. a) Observation of resident rooms 603, and 603 on 5/23/22 at 10:18am revealed room marring/scratches to walls. Resident room 603 further had marring and exposed drywall to the in the bathroom. The paint directly under the sink was observed to be peeling and bubbled with drywall exposed. b) Observation on 5/25/22 at 10:45am revealed Resident room 510 to have dry wall exposed. The area of missing dry wall was directly on the edge of an electrical outlet cover. The drywall was observed to be collecting on the ground directly underneath the hole in the wall with	F 584	Clear Creek Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Clear Creek Nursing and Rehabilitation Center□s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Clear Creek Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceedings.	

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F 584	Continued From page 2 exposed dry wall. The area appeared to be 14 inches in long and 2½ inches wide. Review of the maintenance request log for he month of May 2022 revealed no work order for room 709, 603 or 510. In an interview and observation with the Maintenance Director on 5/26/22 at 7:30am revealed he was made aware of maintenance concerns by staff communication, an electronic work order and residents. He stated he further conducted weekly rounds to determine any maintenance needs. During the observations of rooms 501 and 603, the Maintenance Director stated he was unaware of damaged walls. He stated due there being wall damage in room 501 beside an electrical outlet it was priority. Room 603 would require mudding and the bubbled paint was likely due to water. 2. a) Observation on 5/23/22 at 12:21pm revealed a leak to be in the bathroom of resident room 706 from the plumbing connected to the toilet. The pipe was wet to touch. There was a towel with a trashcan on top directly underneath the plumbing. b) In another observation of resident room 706 revealed a white sheet to be under a trashcan directly under the plumbing connected to the toilet. The towel was damp to touch, and the pluming had visible water droplets. The plumbing connected to the toilet was wet to touch. Review of the maintenance request log for the month of May 2022 revealed no work order for room 706. In an interview with the Maintenance Director on	F 584	Identified resident rooms #510, 603 and 709 dry wall integrity were repaired on 5/26/2022 by Maintenance Director and Maintenance Assistant. Identified residents room #706 leaking toilet was repaired on 6/2/2022 by Contracted Company. A 100% resident room audit of dry wall integrity and toilet leaks was completed on 5/26/2022 by Department Managers. Identified rooms with dry wall marring repairs were completed by 6/3/22 by Maintenance Director and Maintenance Assistant. No other identified toilet leaks found. Education provided to Maintenance Director and Maintenance Assistant on using outside contractor when unable to make repairs on 5/26/2022 by Administrator. Education provided to all staff on Tels Work Order System and how & when to enter a work order completed on 6/14/2022 by Staff Development Coordinator. Newly hired staff and/or agency to be educated prior to start. Department managers to complete room rounds weekly for 4 weeks and monthly for 2 months to ensure work orders for any repairs are completed using Rounding Audit Tool. Administrator to review Tels Work Order system weekly times 4 weeks and monthly for 2 months to ensure all works orders are completed and fixed. Administrator will report the findings of the	

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F 584	Continued From page 3 5/25/22 at 10:35am revealed he was aware of resident room 706 having a leak in the toilet. The Maintenance Director further revealed the issue had been reoccurring but unresolved. He stated he previously attempted to resolve the issue by pouring cement in the area the leak was coming from. The facility water pressure caused the leak and for him to fix the concern he would have to cut the water off for the entire facility. In an interview and observation with the Maintenance Director 5/26/22 at 7:30am revealed room 706 had issues with leaking for about 2 weeks. He further stated the issue was due to water pressure. Observation and interview with the Administrator on 5/26/22 at 7:55am revealed she was unaware of the leak from the toilet in room 706. She stated the issue should have been reported and fixed. She further revealed she was unaware of the walls that had missing dry wall and marring in rooms.	F 584	monitoring wall integrity and leaks to the monthly Quality Improvement (QI) Committee meeting. The QI Committee will review for further recommendations for follow up as needed or continued compliance to determine the need and/or frequency of the continued QI monitoring to ensure compliance is maintained. Completion date: 6/15/2022	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the area of non pressure related skin conditions (Resident #35), vision (Resident #56), weight loss (Resident #21), area of dental (Resident #28) and eating and range of motion (ROM) (Resident #18) for 5 out	F 641	Identified resident #35 Minimum Data Set assessment for non-pressure related skin condition was modified and transmitted on 6/15/2022 by Minimum Data Set Nurse Consultant. Identified resident #56 Minimum Data Set assessment for vision impairment was modified and transmitted	6/20/22

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F 641	Continued From page 4 of 24 residents reviewed. The findings included: 1) Resident #35 was admitted to the facility on 3/19/22 with a diagnosis' that included cellulitis of groin, groin ulcer, chronic venous insufficiency with a history of deep vein thrombosis (DVT) bilaterally and muscle weakness. Nursing progress note dated 3/19/22 revealed Resident #35 had cellulitis of groin and ulcer of groin. Resident #35's skin check sheet dated 3/19/22 revealed he had an open area to the left side of groin. Review of Resident #35's physician order dated 3/19/22 stated to use the facility's wound care protocol for treatment. Resident #35's skin check sheet dated 3/20/22 revealed he had abrasions in his left groin and right groin. Review of Resident #35's Annual MDS dated 3/24/22 revealed he was cognitively intact, required extensive assistance with bed mobility and was coded for the application of nonsurgical dressings/ointments/medications other than his feet. Resident #35 was not coded for having skin conditions. Interview on 05/26/22 at 10:34am with MDS Nurse #1 revealed she coded the MDS for newly admitted residents by paperwork sent from the hospital/admitting facility, reviewed nurses' notes and through observations. She further stated that ulcers and open areas on the skin should be	F 641	on 6/16/2022 by Minimum Data Set Nurse Consultant. Identified resident #21 Minimum Data Set assessment for weight loss was modified and transmitted on 5/25/2022 by Minimum Data Set Nurse Consultant. Identified resident #28 Minimum Data set assessment for dental loose-fitting dentures was modified and transmitted on 6/14/2022 by Minimum Data Set Nurse Consultant. Identified resident #18 Minimum Data set assessment for dependent eating and range of motion was modified and transmitted on 6/14/2022 by Minimum Data Set Nurse Consultant. A 100% audit of the last 100 days of MDS assessment coding in areas of skin, vison, weight loss, dental status, and eating and range of motion was completed by 6/16/2022 by Minimum Data Set Nurse Consultant. Identified areas for skin conditions, vision, weight loss, dental and eating range of motion were modified and transmitted by 6/16/2022 by MDS Nurse Consultant. On 6/16/2022 the Regional MDS Nurse Consultant educated Minimum Data Set Interdisciplinary Team accuracy of Minimum Data Set Coding. Newly hired staff and/or agency to be educated prior to start. Nurse Managers to audit 5 MDS assessments weekly for 4 weeks and monthly for 3 months to ensure accuracy in the areas of skin, vision, weight loss, dental, eating and ROM for accuracy.	

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F 641	Continued From page 5 coded on the MDS. 2) Resident #56 was admitted to the facility on 05/31/19 with a diagnosis that included Alzheimer's and Dementia (otherwise unspecified), age related cataracts, bilaterally, hypertension and major depressive disorder. Record review of Ophthalmology consult dated 2/13/20 revealed Resident #56 had age related nuclear cataracts, bilaterally. Review of Resident #56's quarterly MDS dated 05/03/22 revealed she was cognitively intact, and vision was assessed as adequate. Interview with MDS Nurse #1 on 05/26/22 at 2:35pm revealed that it was an oversight that Resident #56's vision was inaccurately coded. In an interview with Assistant Director of Nursing (ADON) at 11:40 am revealed the MDS coordinator should utilize residents discharge paperwork, nursing notes and observations to ensure the MDS is coded accurately to reflect the resident's current status. 3. Resident #21 was admitted to the facility on 02/16//21 with diagnoses that included dysphagia and a stroke. The Quarterly Minimum Data Set (MDS) assessment completed on 3/24/22 indicated Resident #21 was cognitively intact. It noted he had no weight loss and was able to eat independently after his meal was set up. It also indicated no swallowing difficulty. Review of care plan for Resident #21 noted a care area for "State of Nourishment less than body requirements, characterized by weight loss	F 641	Director of Nursing will report the findings of the monitoring of MDS coding accuracy to the monthly Quality Improvement (QI) Committee meeting. The QI Committee will review for further recommendations for follow up as needed or continued compliance to determine the need and/or frequency of the continued QI monitoring to ensure compliance is maintained. Completion Date: 6/17/2022	

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and loss of appetite. This was initiated on 04/19/21 and revised on 04/22/22.

Record Review for Resident #21 revealed the following weights:
12/3/2021 174.0 Pounds (Lbs.)
01/14/2022 157.4 Lbs.
01/22/2022 147.5 Lbs.
01/27/2022 156.6 Lbs.
02/1/2022 158.4 Lbs.
02/4/2022 113.6 Lbs.
02/8/2022 113.1 Lbs.
02/10/2022 116.0 Lbs.

Review of the Resident census indicated Resident #21 was hospitalized from 02/27/22-03/17/22.
Record review indicated no weight was done on readmission and weekly weights ordered x 4 weeks. Two of the four weights were documented as refused and the other 2 weights were not documented. The next weight documented was on 5/4/2022 at 118.4 Lbs.

An interview with Resident #21 was completed on 05/23/22 at 4:16 PM and he stated he felt he had lost weight. He said he liked the food that was served and ate well.

MDS Nurse #1 was interviewed on 05/26/22 at 3:02 PM regarding the MDS for Resident #21. She was asked to review the MDS from March 2022. She noted she was part time and the other MDS nurse had recently left, so staff from other facilities and corporate were helping to complete the assessments. She reviewed the MDS from 03/24/22 and noted it was documented for no weight loss. She stated it should have been marked "Yes" for weight loss. She had

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completed the final assessment completion verification and stated she would correct the assessment.

The Director of Nursing (DON) was interviewed on 05/26/22 at 4:15 PM regarding Resident #21. She stated the weight loss on the MDS assessment should be coded correctly and she would expect that it would be kept updated.

The Administrator was on 05/26/22 at 4:35 PM regarding the weight loss being coded as "No." She stated the MDS should capture what was in the medical record for the resident.

4). Resident #28 was admitted to the facility on 7/7/21 with a diagnosis of heart failure

The Minimum Data Set (MDS) admission assessment dated 7/14/21 coded Resident #28 as 'No' for having broken or loosely fitting full or partial denture (chipped, cracked, uncleanable, or loose).

The Minimum Data Set (MDS) assessment dated 3/31/22 coded the Resident #28 as being cognitively intact. Resident #28 required minimal supervision to complete most personal hygiene tasks and was independent with bed mobility, walking and transfers and no impairment with range of motion. Resident #28 was coded as 'No' for having broken or loosely fitting full or partial denture (chipped, cracked, uncleanable, or loose).

A review of dental visits from 8/4/21 to 5/11/22 revealed Resident #28 had not been scheduled to see the dentist since admission of 7/14/21.

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An observation an interview with Resident #28 on 5/23/22 at 11:33 AM revealed her top dentures had been noticeably slipping when she talked. Resident #28 had taken out her top dentures and stated the other half is broken and needs to be repaired.

An interview on 5/24/22 at 4:39 PM with Resident #28 stated that her dentures had been that way when she was admitted to the facility.

An interview on 5/25/22 at 9:45 AM with Nurse #3 stated that she Resident #28 was independent with all her personal hygiene tasks and Nurse #3 was aware of her broken denture.

An interview was completed with MDS Nurse #1 on 5/26/22 at 1:33 PM stated that the Social Worker (SW) schedules the dental visits. MDS Nurse #1 stated that when a resident is assessed for dental, the assessment would be done in person and stated that Resident #28 had not complained about her dentures but should get it fixed. MDS Nurse #1 stated that it was an oversight that it was not coded correctly on the MDS and stated that the resident had no issues with eating or swallowing.

An interview was completed with the SW on 5/26/21 at 2:07 PM stated that Resident #28 had not been seen by the dentist, however had been scheduled but there had been an issue with insurance. The SW stated that list was not generated for the next visit but will make sure she is on it.

An interview with the Administrator on 5/26/22 at 4:56 PM stated that the MDS should be coded

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correctly based on what the problem area is related to dentures.

5). Resident #18 was admitted to the facility on 6/2/21 with a diagnosis of Parkinson's disease.

A care plan with a revision date of 3/9/22 had a goal for activities of daily living (ADL) that personal care will be completed with staff support with interventions for eating to provide extensive physical assistance for eating and encouragement remaining with resident during meals. A care plan with a revision date of 3/14/22 had a focus area for risk of falls characterized by history of falls/actual falls injury multiple risk factors related to incontinence, impaired mobility, and Parkinson's diagnosis.

A review of Occupational Therapy (OT) Plan of care with a start date of 3/28/22 to 4/18/22 revealed Resident #18 was being seen due to new onset of muscle spasms throughout right upper extremity and exhibits pain and limited mobility in right shoulder and elbow resulting in reduced ADL participation such as feeding with increased spillage and fatigue. Underlying impairments on the OT plan read in part; motor control, fine motor control left and right upper extremity severely impaired, range of motion left upper extremity completes 75% of normal range and range of motion for right upper extremity completes 50% of normal range.

The Minimum Data Set (MDS) assessment dated 3/31/22 coded resident #18 as being cognitively intact and required extensive assistance with bed mobility, transfers, locomotion on unit and required the assistance of one staff and used a wheelchair for mobility. Resident #18 was coded

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independent for eating - no help or staff oversight at any time with set up only for staff assistance. Resident #18 was coded as no impairment in functional limitation in range of motion for both upper and lower extremities.

An observation of resident #18 on 5/23/22 at 12:35 PM revealed staff had fed Resident #18 for his lunch meal.

An interview on 5/25/22 at 8:56 AM with Nurse Aide #8 (NA) revealed that she did assist resident #18 with breakfast and stated that resident does get assistance with all three meals and had an adaptive spoon.

An interview with Occupational Therapist #2 (OT) on 5/25/22 at 10 :03 AM stated that Resident #18 had been seen on 3/28/22, through 4/18/22 for pain in right upper extremity, range of motion in his right arm and contracture of his right shoulder. OT #2 stated that Resident #18 would be starting OT as of 5/25/22 for a decline in eating and self-feeding. OT #2 stated that he is not independent with feeding but had been a standby assist and supervision with adaptive equipment.

An observation on 5/25/22 at 12:46 PM of Resident #18 who was being fed by OT #2. OT#2 stated that he used to use his right hand but does not anymore and had gotten stiffer in his shoulder and neck.
An interview with the Assistant Director of Nursing (ADON) on 5/25/22 at 5:20 PM who stated that Resident #18 would be able to feed himself with the right adaptive silverware for some of the meal, but staff would assist Resident #18 with feeding for the rest of the meal.

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F 641	Continued From page 11 An interview with the MDS Nurse #1 on 5/26/22 at 1:33 PM stated that the MDS coding for eating was not correct for Resident #18 and that the NA's are the ones who indicate the assistance a resident needed. MDS Nurse #1 stated that if she had done this MDS assessment, she would have observed Resident #18 while eating. MDS #1 stated that Resident #18 did have an impairment for both lower and upper extremities and coding 'no' for range of motion was wrong and would take care of this right away. An interview with the Administrator on 5/26/22 at 4:56 PM stated that the MDS should be coded correctly based on what problem area is related to eating and range of motion	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse	F 656		6/18/22

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F 656	Continued From page 12 treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to develop a comprehensive care plan for 1 of 2 residents (Resident #35) reviewed for non-pressure related skin issues. Findings included: Resident #35 was admitted to the facility on 3/19/22 with a diagnosis that included, cellulitis of groin, groin ulcer, chronic venous insufficiency with a history of deep vein thrombosis (DVT) bilaterally and muscle weakness. Nursing progress note dated 3/19/22 revealed Resident #35 had cellulitis of groin and ulcer of groin. Review of Resident #35's Annual MDS dated	F 656	Identified resident #35 Comprehensive Care Plan was developed to include non-pressure related skin issues on 5/25/2022 by Nurse Consultant. Resident was seen by provider on 6/8/2022 with no change to his Plan of Care. A 100% audit of resident□s comprehensive care plan for non-pressure related skin issues was completed on 6/17/2022 by Assistant Director of Nurses. Identified resident comprehensive care plan for non-pressure related skin issues was reviewed and updated on 6/17/2022.	

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F 656	Continued From page 13 3/24/22 revealed he was cognitively intact, required extensive assistance with bed mobility and was coded for the application of nonsurgical dressings/ointments/medications other than to his feet. Review of Resident #35's comprehensive care plan dated 3/19/22 revealed there was no care plan to address non-pressure skin impairment. Interview on 05/26/22 at 10:34am with the MDS Coordinator revealed she coded the MDS for newly admitted residents by paperwork sent from the hospital/admitting facility, reviewed nurses' notes and through observations. She further stated that residents that have skin conditions or open areas that require treatments should be care planned. In an interview with Assistant Director of Nursing (ADON) on 5/26/22 at 11:40am revealed in the instance a resident was admitted with or developed skin impairments a care plan should have been developed that included interventions for care that included preventative measures and treatments by the physician.	F 656	Regional Minimum Data Set Consultant educated Minimum Data Set Nurse and Licensed Nurse Managers on proper process of development/implementation of comprehensive care plans on 6/16/2022. Education initiated with Licensed Nurses on proper development/implementation of comprehensive care plans to be completed by 6/17/2022 by Staff Development Coordinator. Newly hired staff and/or agency to be educated prior to start. Director of Nurses to audit 5 residents comprehensive care plans weekly for non-pressure related skin issues weekly for 4 weeks and monthly for two months to ensure comprehensive care plans are developed. Director of Nursing will report the findings of the monitoring of Comprehensive Care Plan development to the monthly Quality Improvement (QI) Committee meeting. The QI Committee will review for further recommendations for follow up as needed or continued compliance to determine the need and/or frequency of the continued QI monitoring to ensure compliance is maintained. Completion date: 6/18/2022	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of	F 657		6/20/22

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F 657	Continued From page 14 the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff interviews, and observations the facility failed to revise a care plan for weight loss for 1 of 3 residents reviewed for care plan revisions and failed to revise the care plan for palliative care for 1 of 3 residents reviewed. (Resident #20, Resident #36) Findings included: 1. Resident #20 was admitted to the facility on 03/25/21 with diagnoses that included dementia, muscle weakness and stroke. Record Review for Resident #20 revealed the	F 657	Identified resident #20 care plan was reviewed and revised for weight loss on 5/26/2022 by Assistant Director of Nurses. Identified resident #36 care plan was reviewed and revised for Palliative Care on 5/25/2022 by Nurse Consultant. An 100% audit of care plans for residents with weight loss was completed on 6/2/2022 by Nurse Consultant. Identified resident care plans were reviewed and updated to include weight loss. An 100% audit of care plans for residents with palliative care was completed on	

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F 657	Continued From page 15 following weights: 11/16/2021 166.2 pounds (Lbs.) 12/10/2021 154.8 Lbs. 12/20/2021 157.0 Lbs. 1/12/2022 160.4 Lbs. 2/3/2022 152.4 Lbs. 3/13/2022 155.6 Lbs. Review of the care plan for Resident #20 noted a care area for "State of nourishment; CVA, swallowing difficulty, cognitive impairment, wound healing". This was initiated on 03/14/2022. Weight loss was not noted. Interventions included: o Will tolerate diet/consistency without difficulty through next review o Will have no significant weight changes through next review The Significant Change Minimum Data Set (MDS) Assessment completed on 03/23/22 indicated no weight loss had occurred and Resident #20 was totally dependent for eating. The resident required assistance of 1 person for feeding. The assessment noted the resident had significant cognitive impairment. Record review for ongoing weights for Resident #20 revealed: 03/24/2022 145.7 Lbs. April 2022 No weight recorded 05/25/22 118.2 Lbs. An observation was conducted on 05/24/22 at 9:10 AM of Resident #20. He opened his eyes when his name was called, but he had no verbal response to questions. Nurse Aide (NA) #5 was interviewed on 05/24/22	F 657	6/18/2022 by Assistant Director of Nurses care plans were updated to include Palliative Care. Education was provided with all Licensed Nurses and Department Managers on care plan revision by Staff Development Coordinator by 6/17/2022. Newly hired or agency to be educated prior to start of shift. Nurse managers to audit all residents with weight loss weekly for 4 weeks and monthly for 2 months to ensure care plans are revised. Social Worker to audit all residents on Palliative Care weekly for 4 weeks and monthly for 2 months to ensure care plans are revised. Director of Nursing will report the findings of the monitoring of care plan revisions for weight loss and palliative care to the monthly Quality Improvement (QI) Committee meeting. The QI Committee will review for further recommendations for follow up as needed or continued compliance to determine the need and/or frequency of the continued QI monitoring to ensure compliance is maintained. Completion Date: 6/18/2022	

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at 9:00 AM that had fed Resident #20 breakfast on 05/24/22. She stated he had eaten 25% of his breakfast and then he had clenched his mouth shut. She noted his appetite had decreased and he was not as alert as he had been.

NA #7 was interviewed on 05/25/22 at 10:59 AM regarding Resident #20. She stated she had fed him breakfast that morning on 05/25/22, but he did not eat much. She noted he would drink but was not eating as much. She said other meals he usually ate well, and in the past, he had eaten about 85% of his breakfast.

The Dietician was interviewed on 05/24/22 at 2:28 PM regarding Resident #20's weight loss. She noted she had been covering the facility since the middle of March. She was asked about his weight loss, and she said she had recently asked the facility about weights not being done. The Dietician said per protocol weights should be done at least monthly. She noted his documented intake was usually 75-100% and he received several protein supplements recently. She said on 05/07/22 a protein supplement, Arginaid was ordered. The dietician said they counted on nursing to document the meals correctly and the documentation was showing 100% on his meals per the NA's. She had requested a re-weigh on 5/20/22 and it had not been done yet. His weight was logged on 05/17/22 as 102.4 and she did not think that was correct.

A phone interview was conducted on 05/26/22 at 11:38 AM with the Nurse Practitioner (NP) regarding Resident #20's weight loss. She stated the weights should be done as ordered and at a minimum, weight should be done monthly to

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watch for a decline. She noted with a significant decline they should have been called. The NP stated with his presssure ulcers not healing and additional wounds identified yesterday, his nutrition was important. The NP noted the resident has declined recently in his cognition and now required total assistance with care. She said nutrition and turning were key factors for him.

The Medical Director (MD) was interviewed on 05/26/22 at 12:20 PM and was asked about Resident #20's weight loss. He noted the weights were not getting done. He said they needed to be notified of the decline in weights so it could be addressed. The MD stated his was a function of his overall decline, but the weights should have been done. He said it would give more information to take to the families and help him to develop a plan toward comfort care if indicated.

An interview was conducted on 05/26/22 at 2:25 PM with the Assistant Director of Nursing (ADON) regarding the care plans. She stated the care plan should be updated by the unit nurse, but several did not know how. She said the MDS nurse, ADON, and Director of Nursing (DON) would often update them with new orders. She noted with weight loss, the dietician or the dietary manager could modify the care plan, but she did not know if they knew how to make changes also.

The DON was interviewed on 05/26/22 at 4:15 PM regarding the care plan for Resident #20 for weight loss. She said any nurse can update the care plan, as well as the ADON, DON and MDS nurse. The DON stated the care plan should include information related to weight loss when indicated.

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F 657	Continued From page 18	F 657		

An interview with the Administrator was completed at 05/26/22 at 4:35 PM regarding care plans not being updated for weight loss. She stated the care plan should capture what was in the medical record for the resident. She also noted the weights should be completed monthly or as ordered and if a gain or loss occurred, they should notify the Dietician and Provider. The Administrator noted the documentation of meals should be done consistently for each meal.
2. Resident #36 was admitted to the facility on 6/11/18 with a diagnosis which included multiple sclerosis, acute respiratory failure, and pulmonary embolism.

The Minimum Data Set (MDS) assessment dated 4/4/22 coded the resident as being severely cognitively impaired.
A review of the care plan created on 6/13/18 with the last revision date of 4/22/22 revealed palliative care was not on the care plan.

A review of the resident's medical record revealed Resident #36 was being seen for palliative care services since 2/10/2020. A palliative medicine visit log revealed Resident #36 was being seen monthly for palliative care with the last visit on 5/11/22.

An interview was completed with the Director of Nursing on 5/25/22 at 10:18 AM who stated that palliative care should be documented on the care plan.

An interview was completed with a palliative care Nurse on 5/26/22 at 1:01 PM who stated that Resident #36 had been seen monthly and had been getting palliative care since 2/10/2020.

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F 657	Continued From page 19 An interview was completed with the MDS Nurse on 5/26/22 at 4:28 PM who stated that palliative care should be on the care plan and any of the nurses could have put it on the care plan. The MDS nurse stated it would be up to nursing to ensure care plans were updated. An interview was completed with the Administrator on 5/26/22 at 4:56 PM who stated that the care plans should be comprehensive and based on what services the resident needs.	F 657		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews the facility failed to apply bilateral elbow rolls for 1 of 3 residents reviewed for positioning (Resident #36).	F 688	Identified resident #36 bilateral elbow rolls were placed on resident for positioning on 5/26/2022 by Nurse Aide. Providers visit with resident on 6/9/2022	6/20/22

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F 688	Continued From page 20 Finding Included: Resident #36 was admitted to the facility on 6/11/18 with a diagnosis which included contracture of the left and right elbow, acute respiratory failure, and pulmonary embolism. A review of an Occupational Therapy plan of care with a start date of 11/17/21 through 12/30/21 revealed Resident #36 had been seen due to contractures of right and left shoulder and decrease in passive range of motion in both shoulder flexion/abduction and elbow flexion/extension. The discharge plan dated 12/30/21 indicated Resident #36 to have modified pillow support for both upper extremities. The Minimum Data Set (MDS) assessment dated 4/4/22 coded the resident as being severely cognitively impaired and coded Resident #36 as having functional limitation in range of motion for both upper extremities with impairment on both sides. Review of Resident #36's care plan dated 4/4/22 revealed a care plan goal; Dependent on staff for activities of daily living/personal care related to advanced multiple sclerosis with severe cognitive impairment with a intervention for staff to don/doff bilateral elbow extension bean bag splints daily. A review of an Occupational Therapy discharge plan dated 5/3/22 revealed Resident #36 had been seen from 3/27/22 to 5/3/22 due to contractures of both right and left shoulder. The discharge plan read in part, resident to receive assistance for Activities of daily living, soft rolls to prevent contractures.	F 688	no distress noted and to continue with plan of care. On 6/16/2022 the Director of Nurses and Assistant Director of Nurses completed 100% audit of residents requiring splints/braces to increase/prevent decrease in Range of Motion (ROM)/mobility. On 6/17/2022 splints/braces per Licensed Provider orders and/or Therapy recommendations were added to EMAR and Care plan for nurses to ensure the residents requiring splints/braces to increase/prevent decrease in Range of Motion (ROM)/mobility are in place as resident tolerates by Director of Nurses and Assistant Director of Nurses. Education provided to all Licensed Nurses to ensure they are following orders for donning and doffing spints/braces as ordered by 6/17/2022 by Director of Nurses and Staff Development Coordinator. Director of Nursing cross-trained 100% CNAs in applying splints/braces to increase/prevent decrease in Range of Motion (ROM)/mobility as resident tolerates by 6/17/2022. Newly hired staff and/or agency to be educated prior to start. Nurse managers to audit splints/braces to ensure proper placement, care plan and orders are in place for 5 residents weekly for 4 weeks and monthly for 2 months. Director of Nursing will report the findings of the monitoring of splints/brace placement, care plans and orders to the	

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F 688	Continued From page 21 An observation on 5/23/22 at 11:16 Am of Resident #36's room had a sign with instructive pictures above her bed that read; place rolls at elbows when supine and lying on her side. An observation of resident revealed no elbow rolls were applied to Resident #36. An observation on 5/23/22 at 3:46 PM of Resident #36 revealed no elbow rolls had been applied to the Resident #36. An observation on 5/24/22 at 4:34 PM of Resident #36 lying in bed with arms crossed revealed no elbow rolls had been applied to Resident #36. An observation on 5/25/22 at 9:10 AM revealed no elbow rolls had been applied to the Resident #36. An interview was completed with NA #5 on 5/25/22 at 9:10 AM who stated who stated that she had not worked with Resident #36 often but stated approximately a week ago noticed the staff has had put rolled up blankets under her elbows. NA #5 stated she was not exactly sure what she is supposed to have by her elbows. An interview was completed with OT #2 on 5/25/22 at 9:55 AM who stated that she had treated Resident #36 for both upper extremities and had used a soft blanket and rolled it into a pillowcase which had been placed under Resident #36 elbows to create a cushion as she would tend to cross her arms at her chest. OT #2 stated she was to have the elbow rolls on all day long and trusted the staff are applying them. OT #2 stated that when she had discharged the	F 688	monthly Quality Improvement (QI) Committee meeting. The QI Committee will review for further recommendations for follow up as needed or continued compliance to determine the need and/or frequency of the continued QI monitoring to ensure compliance is maintained. Completion Date: 6/18/2022	

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resident on May 3, 2022, the staff had been consistent with applying the elbow rolls. An observation was completed on 5/25/22 at 10:08 PM with the OT #2 in Resident #36's room. OT #2 observed the elbow rolls were not in place and looked in Resident #36's room for the elbow rolls/supports and there were not in her room.

An interview on 5/25/22 at 12:27 PM was completed with OT #1 who stated that she had done previous assessment of Resident #36 and at one point she had bean bags splints under her elbows however, OT #2 had initiated the use of a soft roll to be placed at elbows and that was what was currently being used.

An interview on 5/25/22 at 5:26 PM with the Assistant Director of Nursing (ADON) who stated the Nurse Aides put elbow rolls on Resident #36 and they should be on every day. An observation of Resident #36 on 5/25/22 at 5:37 PM in her room with the ADON. Resident #36 had a right elbow roll (a fleece blanket rolled up) under her arm and a bean bag splint on right elbow.

An interview on 5/26/22 at 9:09 AM was completed with NA #6 who stated that she would get a nurse or therapist to put on the elbow rolls as Resident #36 was so contracted she did not want to hurt her.

An addtional interview was completed with the ADON on 5/26/22 at 1:25 PM who stated that Nurse Aides were responsible for applying the elbow rolls as it was a positioning task.

An interview was completed with the Administrator on 5/26/22 at 4:56 PM who stated that if a resident had therapy the staff should be

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CLEAR CREEK NURSING & REHABILITATION CENTER	10506 CLEAR CREEK COMMERCE DRIVE MINT HILL, NC 28227

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F 688	Continued From page 23 following any interventions put in place by therapy.	F 688		
F 726 SS=E	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §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, observation and staff	F 726	On 5/25/2022 identified nurses #3 and #4	6/18/22

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F 726	Continued From page 24 interview the facility failed to provide competency on glucometer cleaning/disinfecting for 2 of 3 nurses (Nurse #3, and Nurse #4) observed during medication administration observations not performing glucometer cleaning/disinfecting per the facility policy. Findings included: The Glucometer Cleaning and Disinfecting Policy with a revision date of 4/2013 stated if there was no visible blood or bodily fluids present on the glucometer it should be cleaned using a germicidal disposable cloth/wipe to thoroughly wet the entire external surface of the glucometer; then cover/wrap the entire glucometer in the wipe; and place the glucometer in a plastic disposable cup on the medication cart and allow the full minutes' exposure time according to the manufacturer's product directions, removed the cloth, wipe and discard, and return the glucometer to the cup to allow it to thoroughly air dry. The General Guidelines for Use for the facility's germicidal disposable wipes stated the surface being cleaned should remain wet for 2 minutes and then be allowed to air dry. The guidelines also stated the wipes were not to be reused on another surface. A. During an observation and interview with Nurse #3 on 5/25/2022 at 7:48 am she returned to the medication cart after being observed obtaining a finger stick blood sugar and placed the glucometer back into the medication cart without cleaning it. When asked when she should clean/disinfect the glucometer, she took it out of the medication cart drawer and wiped it	F 726	received education and competency on glucometer cleaning/disinfecting with return demonstration by Director of Nurses. On 5/25/2022 100% of present nurses received education and competency on glucometer cleaning/disinfecting with return demonstration by Director of Nurses Education and competency on glucometer cleaning/disinfecting with return demonstration completed by 6/30/2022 by Director of Nurses and Staff Development Coordinator. Licensed Nurses completed glucometer education and competency on cleaning/disinfecting prior to the start of their shifts. Newly hired staff and/or agency to complete glucometer education and competency on cleaning/disinfecting prior to start. Nurse managers will complete competency with return demonstration with 4 nurses on different shifts/hall weekly for 4 weeks and monthly for 2 months to ensure nurses are able to show return demonstration of cleaning/disinfecting glucometer. Director of Nursing will report the findings of the monitoring of glucometer cleaning/disinfecting with return demonstration to the monthly Quality Improvement (QI) Committee meeting. The QI Committee will review for further recommendations for follow up as needed or continued compliance to determine the need and/or frequency of the continued QI	

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F 726	Continued From page 25	F 726		

with a sanitizing wipe and set it back in the cart, she did not wrap the glucometer in a wipe or allow it to air dry. She began wiping the outside of her cart with the same sanitizing wipe. Nurse #3 stated she worked at the facility as an agency nurse and her contract ended at the end of her shift. She stated she had worked at the facility for three weeks and had not received training on the facility's glucometer cleaning protocol.

B. During an observation and interview with Nurse #4 on 5/25/2022 at 4:36 pm she returned to the medication cart after obtaining a finger stick blood sugar for Resident # 47 and did not sanitize the glucometer. Nurse #4 was observed preparing to obtain a finger stick blood sugar for the next resident, Resident #59. Nurse #4 gathered the supplies from the medication cart and entered Resident #59's room to do her finger stick blood sugar without cleaning/disinfecting the glucometer between residents. Nurse #4 was stopped before she began the finger stick blood sugar and when asked why she did not clean/disinfect the glucometer she stated she forgot. Nurse #4 went back to the medication cart and wiped the glucometer with a sanitizing wipe and then let it dry for 1 minute, and then she wiped it with an alcohol wipe. Nurse #4 did not allow the glucometer to dry after the alcohol wipe was used and went into the resident's room and obtained her blood sugar. Nurse #4 stated she forgot to clean the glucometer and she did not remember having an education regarding how to clean the glucometer.

An interview was conducted with the Director of Nursing on 5/26/2022 at 10:14 am and she stated one of the nurses had notified her she had not disinfected/cleaned a glucometer during an

monitoring to ensure compliance is maintained.

Completion Date: 6/18/2022

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F 726	Continued From page 26 observation. The Director of Nursing stated all nurses, including agency staff, were educated on how to clean a glucometer during orientation. She stated all nurses should follow the facility's protocol for cleaning/disinfecting the glucometers after each use. The facility was not able to provide in-service training regarding disinfection of glucometers for Nurse #3, Nurse #4, or Nurse #5. During an interview with the Administrator on 5/25/2022 at 3:17 pm she stated the nursing staff should be educated and follow the policy for how to clean the facility's glucometers.	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. §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 ensure the full-time Director of Nursing(DON) worked as a full-time DON for 5 of 23 days reviewed of the facility's nursing	F 727	Reviewed identified nursing schedule for days 5/1/2022, 5/9/2022, 5/10/2022, 5/14/2022 and 5/15/2022 for full time Director of Nurses by Administrator on	6/14/22

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F 727	Continued From page 27 schedule. 5/01/22, 5/09/22, 5/10/22, 5/14/22 and 5/15/22. Findings included: A review of the facility's nursing schedules for 5/01/22 to 5/23/22 indicated the DON was assigned to a nurse assignment on 5/01/22, 5/09/22, 5/10/22 and 5/15/22. The census was above 63 residents on 5/01/22, 5/09/22, 5/10/22, 5/14/22 and 5/15/22. On 5/23/22 at 11:42 AM the nurse staff scheduler was interviewed and revealed he was not aware that if the DON worked a nurse staff assignment for 8 consecutive hours a day those hours could not be counted as an RN assignment and recorded on the daily nurse staffing form posted daily. The nurse scheduler revealed that the DON and Assistant Director of Nursing (ADON) were the only RNs the facility employed and the facility used mainly agency staff, but an RN was not included in agency staff. An interview with the DON conducted on 5/26/22 at 12:37 PM revealed she had worked as a staff nurse on days when the facility did not have a registered nurse (RN) to work 8 consecutive hours a day on various days. The DON explained the ADON was also assigned as a staff nurse on some days that the facility had difficulty scheduling an RN to work for 8 consecutive hours a day as required.	F 727	5/26/2022. Administrator completed audit for 5/26/2022 through 6/13/2022 for any days without a full time Director of Nurses on 6/13/2022 with no negative findings. Education was provided to Administrator and Director of Nursing on ensuring a full time Director of Nurses is on duty by Regional Vice President on 5/26/2022. Newly hired staff and/or agency to be educated prior to start. Regional Vice President to audit schedule weekly for 4 weeks and monthly for 2 months to ensure facility has a full time Director of Nurses. Administrator will report the findings of the monitoring of a full time Director of Nurses to the monthly Quality Improvement (QI) Committee meeting. The QI Committee will review for further recommendations for follow up as needed or continued compliance to determine the need and/or frequency of the continued QI monitoring to ensure compliance is maintained. Completion Date: 6/14/2022	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		6/20/22

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F 812	Continued From page 28 §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 record reviews, staff interviews and observations the facility failed to date an opened nectar thickened milk container stored for use in the refrigerator for 1 of 1 nourishment room (Nourishment Room for the 500, 600 and 700 halls) reviewed, failed to date opened food items that were stored for use in 1 of 1 reach-in freezer observed and failed to ensure stacked plastic dishware was stored dry. These practices had the potential to affect the food served to residents. Findings included: A tour of the kitchen was conducted on 05/23/22 at 10:06 AM with the Dietary Manager. 1. An observation of the walk in cooler and freezer was done on 05/23/22 at 10:10 AM and revealed the following items did not have an	F 812	The identified cool whip cream, ice burg lettuce, frozen zucchini, and cheese omelets were discarded on 5/23/22 from reach in cooler/freezer by Dietary Manager. The identified personal drink was discarded on 5/25/22 from walk in freezer by Dietary Manager. The identified nectar thick milk was discarded on 5/26/22 from nourishment room on 500/600 hall by the Dietary Manager. Identified stacked plastic dishware was ran through dishwasher, dried properly, and stored on 5/23/2022 by Dietary Manager. On 6/9/2022 Dietary Consultant completed Dietary Sanitation Audit of kitchen to include food storage in coolers and freezers, Staff personal food and items, and Nourishment rooms on 300,	

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F 812	Continued From page 29 opened date: A 16 ounce (oz) whip cream container that was 50% used was noted without an opened date. During an interview with the Dietary Manager on 05/23/22 at 10:11 AM, he stated the whip cream should have been dated when opened. He stated the staff that opened it, were responsible to have dated it. 2 heads of half heads of iceberg lettuce and a large, opened bag of shredded lettuce were all without dates. It was noted the iceberg lettuce was turning brown on the edges. An interview with the Dietary Manager was done on 05/23/22 at 10:12 AM. He said the lettuce should have been labeled and dated when opened. A 48 oz. opened package of frozen zucchini, with approximately 50% remaining in the bag, was without a label or opened date. An interview was done with the Dietary Manager 05/23/22 at 10:12 AM and he said the zucchini should have been dated when opened. 7 frozen cheese omelets in a plastic bag were opened and without label or an opened date. An interview was done with the Dietary Manager 05/23/22 at 10:12 AM and he said the omelets should have been dated when opened. An observation was done on 05/23/22 at 10:13 AM of an opened can of tropical flavored energy drink, 8.4 oz on a shelf in the walk in freezer.	F 812	400, 500, 600, 700, and 800 with no negative findings. On 6/9/2022 Dietary Consultant educated dietary manager and staff on proper label and dating of opened food, personal items to be stored in break room and storing dishes on drying rack. Newly hired staff and/or agency to be educated prior to start. Dietary consultant to complete Dietary Sanitation Checklist weekly for 4 weeks and monthly for two months to ensure proper label and dated of foods, personal items being stored in break room and dishes being stored dry. Dietary Manager will report the findings of the monitoring of food storage dates, personal items and stacked plastic dishware to the monthly Quality Improvement (QI) Committee meeting. The QI Committee will review for further recommendations for follow up as needed or continued compliance to determine the need and/or frequency of the continued QI monitoring to ensure compliance is maintained. Completion Date:6/9/2022	

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F 812	Continued From page 30	F 812		

An interview conducted with the Dietary Manager on 05/23/22 at 10:13 AM. He stated the drink should not be in the freezer and was a staff member's drink.

On 5/25/22 at 1:46 PM a follow up observation was done with the Dietary Manager of the walk in freezer. A 16 oz. Styrofoam cup of pink lemonade was noted on the shelf.

An interview was done with the Dietary Manager on 05/25/22 at 1:46 PM regarding the pink lemonade drink, he stated it 'appeared to be a staff drink" and it should not be in the freezer.

2. An observation of the Nourishment Room for the 500, 600 and 700 halls was done on 05/26/22 at 1:58 PM with Nurse #7. An 8 oz container of thick and easy nectar consistency milk was open in the refrigerator and no date was noted when opened.

An interview was completed with Nurse #7 on 05/26/22 at 2:00 PM and she confirmed the seal was broken and the drink should have an open date on the container.

The Assistant Director of Nursing (ADON) was interviewed on 05/26/22 at 2:25 PM regarding the undated nectar thickened milk in the nourishment refrigerator. She said the milk should have been dated when opened and used within a day or discarded.

The Dietary Manager was interviewed on 05/26/22 at 2:56 PM regarding the nourishment room and he stated his dietary aides were responsible for checking the refrigerators and

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F 812	Continued From page 31 items should be dated when opened. 3. An observation of the dish washing area was completed on 05/23/22 at 10:25 AM and 12 plate covers were stacked on top of each other on the bottom shelf in the wash/dry area stored wet. The Dietary Manager stated in an interview on 05/23/22 at 10:26 AM, that the plastic dishware should be dried in racks till completely dry. The rack was visible right above the plastic dishware and was empty. He stated once the plastic dishware were dry, they usually took them to the front of the kitchen area for serving. Dietary Aide #1 was interviewed on 05/25/22 at 12:30 PM regarding labeling of food items. She noted the items should be dated when opened. The Assistant Dietary Manager was interviewed on 05/25/22 at 2:10 PM regarding labeling of food when opened. She stated the food should be dated when opened. An interview with the Administrator was done at 05/26/22 at 4:35 PM in reference to the staff drinks in the dietary freezer, and undated opened food in dietary and undated opened nectar thickened milk in the nourishment refrigerator. She noted she would have expected the products to be labeled with the dates they were opened, and staff drinks should not be stored in the refrigerator.	F 812		
F 835 SS=E	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that	F 835		7/1/22

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F 835	Continued From page 32 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, observation, and staff interviews the facility failed to provide effective oversite to ensure 3 of 3 nurses (Nurse #3, Nurse #4, and Nurse #5) were educated regarding glucometer cleaning/disinfecting for residents sampled for a medication administration observation. Findings included: This tag is referred to: F880- Based on observations, record review, and staff interviews the facility failed to implement infection control practices when 3 of 3 nurses (Nurse #3, Nurse #4, and Nurse #5) did not disinfect multi-use blood glucose meters after use per the facility's policy for 3 of 3 resident observations. During an interview with the Administrator on 5/25/2022 at 3:17 pm she stated the nursing staff should be educated and follow the policy for how to clean the facility's glucometers.	F 835	On 5/25/2022 Director of Nurses/ Infection Control Preventionist implemented infection control practices by providing identified nurses #3, #4 and #5 education and competency on glucometer cleaning/disinfecting with return demonstration. Nurse consultant educated Director of Nurses, Assistant Director of Nurses and Staff Development Coordinator on training licensed nurses on glucometer cleaning/disinfecting with return demonstration prior to starting on 5/25/2022. On 5/25/2022 100% of present nurses received education and competency on glucometer cleaning/disinfecting with return demonstration by Director of Nurses. Education and competency on glucometer cleaning/disinfecting with return demonstration completed by 6/30/2022 by Director of Nurses and Staff Development Coordinator implementing infection control practices. Newly hired staff and/or agency to complete glucometer education and competency on cleaning/disinfecting prior to start of shift. Nurse consultant educated Director of Nurses, Assistant Director of Nurses and Staff Development Coordinator on training licensed nurses on glucometer cleaning/disinfecting with	

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F 835	Continued From page 33	F 835	return demonstration prior to starting on 5/25/2022. Newly hired staff and/or agency to complete glucometer education and competency on cleaning/disinfecting prior to start. Nurse managers will complete competency with return demonstration with 4 nurses on different shifts/hall weekly for 4 weeks and monthly for 2 months to ensure nurses are able to show infection control practices by return demonstration of cleaning/disinfecting glucometer. Nurse Consultant to audit 4 licensed nurses weekly for 4 weeks and monthly for 2 months for new nurses or agency for proof of education on glucometer cleaning/disinfection competencies completed by Director of Nurses, Assistant Director of Nurses or Staff Development Coordinator. Director of Nursing and Nurse Consultant will report the findings of the monitoring of infection control practices by glucometer cleaning/disinfecting with return demonstration to the monthly Quality Improvement (QI) Committee meeting. The QI Committee will review for further recommendations for follow up as needed or continued compliance to determine the need and/or frequency of the continued QI monitoring to ensure compliance is maintained. Completion Date: 6/30/2022	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		6/30/22

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

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	345562	A. BUILDING _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 35 depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to implement infection control practices when 3 of 3 nurses (Nurse #3, Nurse #4, and Nurse #5) did not disinfect multi-use blood glucose meters after use per the facility's policy for 3 of 3 resident observations. Findings included: The Glucometer Cleaning and Disinfecting Policy with a revision date of 4/2013 stated if there was no visible blood or bodily fluids present on the	F 880	On 5/25/2022 Director of Nurses/ Infection Control Preventionist implemented infection control practices by providing identified nurses #3, #4 and #5 education and competency on glucometer cleaning/disinfecting with return demonstration. On 5/25/2022 100% of present nurses received education and competency on glucometer cleaning/disinfecting with return demonstration by Director of	

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F 880	Continued From page 36	F 880		

glucometer it should be cleaned using a germicidal disposable cloth/wipe to thoroughly wet the entire external surface of the glucometer; then cover/wrap the entire glucometer in the wipe; and place the glucometer in a plastic disposable cup on the medication cart and allow the full minutes' exposure time according to the manufacturer's product directions, removed the cloth, wipe and discard, and return the glucometer to the cup to allow it to thoroughly air dry.

The General Guidelines for Use for the facility's germicidal disposable wipes stated the surface being cleaned should remain wet for 2 minutes and then be allowed to air dry. The guidelines also stated the wipes were not to be reused on another surface.

An In-service Training Report with Staff Attending Form dated 5/24/2022 was provided by the Director of Nursing. Nurse #3, Nurse #4, and Nurse #5 had not signed the in-service attendance form.

A. During an observation and interview with Nurse #3 on 5/25/2022 at 7:48 am she returned to the medication cart after being observed obtaining a finger stick blood sugar and placed the glucometer back into the medication cart without cleaning it. When asked when she should disinfect/clean the glucometer, she took it out of the medication cart drawer and wiped it with a sanitizing wipe and set it back in the cart, she did not wrap the glucometer in a wipe or allow it to air dry. Nurse #3 stated she worked at the facility as an agency nurse and her contract ended at the end of her shift. She stated she had worked at the facility for three weeks and had not

Nurses.

Education and competency on glucometer cleaning/disinfecting with return demonstration completed by 6/30/2022 by Director of Nurses and Staff Development Coordinator implementing infection control practices. Education included steps of how to disinfect glucometers and how to properly check blood sugars including infection control procedures. Newly hired staff and/or agency to complete glucometer education and competency on cleaning/disinfecting prior to start.

Nurse managers will complete competency with return demonstration with 4 nurses on different shifts/hall weekly for 4 weeks and monthly for 2 months to ensure nurses are able to show infection control practices by return demonstration of cleaning/disinfecting glucometer. Director of Nursing will report the findings of the monitoring of infection control practices by glucometer cleaning/disinfecting with return demonstration to the monthly Quality Improvement (QI) Committee meeting. The QI Committee will review for further recommendations for follow up as needed or continued compliance to determine the need and/or frequency of the continued QI monitoring to ensure compliance is maintained.

Completion Date: 6/30/2022

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received training on the facility's glucometer cleaning protocol.

B. During an observation and interview with Nurse #4 on 5/25/2022 at 4:36 pm she returned to the medication cart after obtaining a finger stick blood sugar for Resident # 47 and did not disinfect the glucometer. Nurse #4 was observed preparing to obtain a finger stick blood sugar for the next resident, Resident #59. Nurse #4 gathered the supplies from the medication cart and entered Resident #59's room to do her finger stick blood sugar without disinfecting the glucometer between residents. Nurse #4 was stopped before she began the finger stick blood sugar and when asked why she did not disinfect the glucometer she stated she forgot. Nurse #4 went back to the medication cart and wiped the glucometer with a sanitizing wipe and then let it dry for 1 minute, and then she wiped it with an alcohol wipe. Nurse #4 did not allow the glucometer to dry after the alcohol wipe was used and went into the resident's room and obtained her blood sugar. Nurse #4 stated she forgot to disinfect the glucometer and she did not remember having an education regarding how to clean the glucometer.

C. During an observation and interview with Nurse #5 on 5/25/2022 at 4:49 pm she obtained a finger stick blood sugar with Resident #4 she returned to the cart after obtaining a finger stick blood sugar and wiped the glucometer with a sanitizing wipe and left it on the cart to dry. Nurse #5 did not wrap the glucometer in a sanitizing wipe. Nurse #5 stated she did not remember having an education on how to clean the glucometers.

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F 880	Continued From page 38 An interview was conducted with the Director of Nursing on 5/26/2022 at 10:14 am and she stated one of the nurses had notified her she had not disinfected/cleaned a glucometer during an observation. The Director of Nursing stated all nurses, including agency staff, were educated on how to clean a glucometer during orientation. She stated all nurses should follow the facility's protocol for cleaning/disinfecting the glucometers after each use.	F 880		