STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING ______ B. WING ______	C 06/17/2022

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UNIVERSAL HEALTH CARE/FUQUAY-VARINA	**410 S JUDD PARKWAY SE** **FUQUAY VARINA, NC 27526**

(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 001 SS=F	Establishment of the Emergency Program (EP) CFR(s): 483.73 §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.625, §485.727, §485.920, §486.360, §491.12 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.) *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The	E 001		7/15/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 07/10/2022

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

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E 001	Continued From page 1 CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to review and maintain a comprehensive Emergency Preparedness (EP) plan. The facility failed to maintain an annual emergency preparedness training and testing program for facility staff and to participate in a tabletop exercise or conducting a full-scale exercise that was community based in the past year. The findings included: A review of the facility's EP manual on 6/17/22 revealed: a.. There was no evidence staff members were receiving annual in-servicing about emergency procedures related to different types of emergency situations b. The manual did not include information on annual training of the emergency preparedness plan for facility staff. c. The facility had no evidence of participating in a tabletop exercise or conducting a full-scale exercise that was community based in the past year. An interview on 6/17/22 at 2:00 PM with the Administrator revealed she came to the facility in April and had been working with the Maintenance	E 001	On 6/21/22 the Maintenance Director and Administrator were educated by the Company Physical Plant Director on the policy and procedures of the facility emergency management plan and the requirements. The Maintenance Director and Administrator started annual training for all staff on the emergency preparedness plan and procedures on 7/11/22 and will be completed by 7/15/22. This education will also be part of new hire orientation. A full-scale emergency preparedness exercise was conducted on 7/1/22. A previous tabletop exercise was also reviewed 6/30/22 An additional tabletop exercise will be completed by 7/15/22. The information for the training and all exercises will be placed in the 2022 Emergency Preparedness Manual on 7/15/22.	

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E 001	Continued From page 2 Director to get the facility ' s emergency preparedness training and testing in place. She stated she was unaware of any tabletop or full-scale exercise that was community based in the past year. She stated she was aware of the requirements for the Emergency Preparedness Plan and the Maintenance Director was responsible for training and testing. On 6/17/22 at 2:16 PM an interview was conducted with the Maintenance Director who stated he was aware staff had to be trained annually on emergency preparedness and believe the facility fire drills on alternating shifts would satisfy the regulation. He further stated no additional in-service training was done about the emergency preparedness plan and was unaware of any full-scale exercise or tabletop exercise done in the past year.	E 001	The maintenance Director will bring the Emergency Preparedness Manual to the monthly during the monthly Quality Assurance and Performance Improvement meeting for review by the committee to ensure it is up to date with all required training and exercises for 3 months. The Emergency Preparedness Plan/Manual will be updated as needed and reviewed annually ongoing according to company policy.	
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from June 13, 2022 through June 17, 2022. Event ID# O2WK11. 35 of the 52 complaint allegations were substantiated resulting in deficiencies. Intake Numbers: NC00184099, NC00184159, NC00184904, NC00185144, NC00185686, NC00185861, NC00186207, NC00186546, NC00186581, NC00186856, NC00187538, NC00187749, NC00188013, NC00188297, NC00188505, NC00189190, NC00189189, NC00189357, NC00190020	F 000		
F 554 SS=E	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7)	F 554		7/15/22

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F 554	Continued From page 3 §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident, staff and physician interviews, the facility failed to assess 3 of 3 residents (Resident #20, Resident #24 and Resident #78) to determine if self-administration of medication was clinically appropriate when medication was observed to be left at the residents' bedside. Findings included: 1.Resident #20 was admitted to the facility on 3-21-22 with multiple diagnosis that included chronic obstructive pulmonary disease The significant change Minimum Data Set (MDS) dated 6-4-22 revealed Resident #20 was cognitively intact. Review of Resident #20's medical record revealed no assessment for self-administration of medication and no physician order for Resident #20 to self-administer medication. An observation of Resident #20's room occurred on 6-13-22 at 10:15am. The observation revealed Resident #20 had 15 cubic centimeters (CC) of a red liquid in a medicine cup and 2 inhalers sitting on her over the bed table. Resident #20 was interviewed on 6-13-22 at 10:16am. The resident stated the nurse (Nurse #5) had left her cough syrup because she did not like to take it before she ate and explained her	F 554	On 06/13/2022 medications removed from bedside for resident # 20 On 06/14/2022 medications removed from bedside for resident # 24 On 06/13/2022 medications removed from bedside for resident # 78 Director of Nursing and ADON completed a facility tour to ensure medications were not left at the bedside for current facility residents. This audit was completed on 07/01/22 through 07/15/2022 Medications are to be given then, if resident does not want to take medications at the appropriate time, staff is to discard of the medication appropriately and document. In person or via telephone by the Director of Nursing or Assistant Director of Nursing or Staff Development Nurse by 7/8/2022. All licensed nurses and medication aides will be educated on not leaving medications unattended at the bedside of the resident. Including contract nursing staff. Any licensed nurse who have not received this education by 7/15/22, will not be allowed to work, until training completed. Newly hired and agency licensed nurses will receive this education during their orientation. Director of nursing and/or designees will	

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F 554	Continued From page 4 inhalers were always left on her table, but the resident stated she did not know why. During an interview with Nurse #5 on 6-13-22 at 1:53pm, the nurse stated she did not know why the resident's inhalers were left in her room but stated "every time I work, they are on her table." Nurse #5 stated Resident #20 did not have any orders that she was aware of to self-administer medication and the inhalers should not be left at her bedside. She also stated she had provided Resident #20 with cough syrup but said the resident had taken the medication. Nurse #5 explained she saw the medicine cup with cough syrup in it on Resident #20's over the bed table but thought it was left from the night before. The nurse stated she did not remove the medication from the bed table. The facility physician was interviewed by telephone on 6-16-22 at 2:30pm. The physician discussed Resident #20's medication and stated the inhaler and cough syrup should not have been left at the bedside and could have caused harm to the resident. He also stated medications should not be left with a resident unless there was a physician order and stated Resident #20 did not have a physician order. The Administrator was interviewed on 6-17-22 at 4:58pm. The Administrator stated no medication should be left at a resident's bedside unless there was an evaluation and physician order. She said Nurse #5 should have waited for Resident #20 to take her medication and remove any medication that had been left. 2. Resident #24 was admitted to the facility on 3-29-19 with multiple diagnosis that included	F 554	audit 5 rooms daily Monday through Friday x 12 weeks to ensure that no medications are left at the bedside. Nurse and/or medication aid found to have practice will be reeducated. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	

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F 554	Continued From page 5 diabetes and chronic obstructive pulmonary disease. The quarterly Minimum Data Set (MDS) dated 3-29-22 revealed Resident #24 was cognitively intact. An observation of Resident #24's room was completed on 6-14-22 at 9:30am. Resident #24 was noted to be in his bed sleeping with a medicine cup that had 9 pills in it on his over the bed table. During an interview with Medication Tech (MT) #2 on 6-14-22 at 9:35am, the MT stated he had left the medicine cup of pills on Resident #24's over the bed table because the resident told him he would take the medication. MT #2 said Resident #24 did not have an order for self-administration of medication and the medication should not have been left on the over the bed table. A telephone interview occurred with the facility physician on 6-16-22 at 2:30pm. The physician stated Resident #24 would have had needed an order for his medication to be left at his bed side and Resident #24 did not have an order so the medication should not have been left there. The Administrator was interviewed on 6-17-22 at 4:58pm. The Administrator stated no medication should be left at a resident's bedside unless there was an evaluation and physician order. She said MT #2 should not have left medication at Resident #24's bed side but should have stayed in the room and watched the resident take his medication. 3. Resident #78 was admitted to the facility on 06/18/2020 with diagnoses which included	F 554		

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F 554 Continued From page 6 F 554

chronic kidney disease and hypertension.

A review of the quarterly Minimum Data Set (MDS) dated 05/13/2022 revealed Resident #78 was cognitively intact.

A review of Resident #78 ' s medical record revealed no assessment for self-administration of medication and no physician order for Resident #78 to self-administer medication.

An observation of Resident #78 ' s room on 06/13/2022 at 11:03 am revealed Resident #78 had a brownish powdered substance in a 30cc (cubic centimeter) medicine cup that was almost half full.

An interview with Resident #78 on 06/13/2022 at 11:03 am revealed Nurse #4 had crushed her "kidney medication" and was going to come back later and help her take it.

An interview with Nurse #4 on 06/13/2022 at 11:05 am revealed she had left the medication, velphoro 500 milligrams (mg), at Resident #78 ' s bedside and planned to go back later to help her take it. Nurse #4 stated she usually waits for residents to take all the medications before leaving the room, but this time she didn't. Nurse #4 stated she should have waited until Resident #78 had taken all of her medications before leaving the room.

An interview with the Director of Nursing (DON) on 06/15/2022 at 10:08 am revealed medications should not be left at the bedside without a physician order and/or an self-administer assessment had been completed per physician request.

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F 554	Continued From page 7 An interview with the Administer on 06/17/2022 at 3:15 pm revealed nurses should not leave medications at bedside without a physician order. The Administrator also added Nurse #4 should have remained at the bedside until all medications were taken.	F 554		
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.	F 561		7/15/22

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This REQUIREMENT is not met as evidenced by:

Based on record review, observation, resident and staff interviews, the facility failed to honor a resident's choice to get out of bed. This occurred for 1 of 2 residents (Resident #20) reviewed for choices.

Findings included:

Resident #20 was admitted to the facility on 3-21-22.

Resident #20's care plan dated 3-28-22 revealed a goal that she would maintain her level of mobility. The interventions for the goal were in part resident requires the assistance of 2 people with transfers.

The significant Minimum Data Set (MDS) dated 6-4-22 revealed Resident #20 was cognitively intact. The MDS coded transfers had not occurred.

Resident #20 was interviewed while lying in her bed on 6-13-22 at 10:15am. Resident #20 stated she did not have any choice if she can get out of bed. She explained when she had asked the Nursing Assistance (NA), they told her they were too short staffed to get her out of bed and stated, "so I really don't have a choice when I get up."

During observation of Activities of Daily Living (ADL) care on 6-15-22 at 9:50am with NA #1, Resident #20 was observed to ask the NA if she could get up in her wheelchair. NA #1 was observed not to respond to Resident #20 and did not get the resident out of bed at the end of the ADL care.

F 561

Resident# 20 is getting out bed as she chooses; however, she refuses most of the time. NA#1's contract was cancelled after shift completed on 06/15/2022.

Director of Nursing (DON) and/or designee will interview alert and oriented residents on their choices as related to getting out of bed by 07/15/2022.

By 7/15/22, current nursing staff, including agency staff was reeducated by Director of Nursing (DON) and/or designee on Resident's Rights related to Choices for dependent residents, who require assistance with transferring out of the bed. Any staff not educated by 07/15/2022 will not be allowed to work until the education is completed. For newly hired staff, including agency staff will receive this education during orientation.

Director of Nursing (DON) and/or Unit Mangers will observe 5 residents daily for 5 days, for 3 weeks, then 3 times per week for 3 weeks, then weekly times 6 weeks to ensure that staff is assisting those residents who requires assistance out of the bed. Any deficiencies noted will be addressed immediately and corrective action taken as necessary, which may include disciplinary action.

A summary of audit results will be completed by the Director of Nursing and presented to the Quality Assurance Performance Improvement Committee meetings monthly x3 months, to ensure

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F 561	Continued From page 9 NA #1 was interviewed on 6-15-22 at 10:00am. NA #1 stated she could not get Resident #20 out of bed right now because she was the only NA working hall 400 and Resident #20 needed 2 people to assist her out of the bed. NA #1 said when she had time, she would try to find someone to help her assist the resident out of the bed. Resident #20 was further interviewed on 6-15-22 at 1:45pm. Resident #20 was observed to be out of the bed and sitting in her wheelchair. The resident stated NA #1 had not assisted her out of the bed, she explained she had physical therapy and the therapist assisted her out of the bed after lunch and took her to the physical therapy room. During an interview with the Administrator on 6-17-22 at 4:58pm, the Administrator stated she expected the residents needs to be met and their request honored. She explained NA #1 should have asked for help to assist Resident #20 out of the bed.	F 561	continued compliance.	
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.	F 578		7/15/22

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F 578	Continued From page 10 §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, staff and physician interviews, the facility failed to accurately document advance directives (code status) throughout the medical record for 2 of 2 residents (Resident #12 and Resident #295) reviewed for advance directives. Findings included:	F 578	Advanced Directives were clarified for resident #12 on 6/20/2022, Social Worker Resident #295 is no longer a resident in the facility. An audit of advanced directives/code statuses for all residents was conducted by the administrative nursing staff on 7/6/2022. All code status orders, and	

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1.Resident #12 was admitted to the facility on 12-10-20

Physician order dated 1-15-22 revealed an order for Resident #12 to be a full code (attempt resuscitation).

The quarterly Minimum Data Set (MDS) dated 3-8-22 revealed Resident #12 was moderately cognitively impaired.

Resident #12's care plan dated 3-18-22 revealed a goal that her wishes would be honored relative to do not resuscitate (DNR) code status.

Review of Resident #12's medical record revealed her face sheet documented she was a DNR and there was an information sheet for DNR code status.

A telephone interview occurred with Nurse #1 on 6-14-22 at 4:44pm. Nurse #1 said she had written the order on 1-15-22 for Resident #12 to be a full code. She explained while she was speaking with the resident, the resident had stated she no longer wanted to be a DNR but wished to be a full code. Nurse #1 stated she did not speak with the family, physician or Social Worker before writing the order. The nurse said she thought Resident #12 could make that decision on her own.

During an interview with the facility Social Worker (SW) on 6-15-22 at 2:10pm, the SW explained she would discuss code status of a resident upon their admission and if the resident remained long term in the facility she would compare the orders, face sheet and care plan to make sure the code status was the same. The SW stated she would compare the orders; face sheet and care plan

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documentation are congruent.

All new admissions will be reviewed on the within 24 hours of admission to ensure admissions orders, including code status is documented, during the facility morning meeting M-F after admission by the facility IDT Team.   Weekend admissions will have their orders verified by two nurses to ensure accurate code status is documented.
Admissions Director, Administrative nurses and Social Worker were in-service on 7/6/2022 by the Administrator regarding completing code status agreement on admission and entering order into EHR.

Director of Nursing and/or SW will review new admission medical records during the clinical meeting 5 days per week for 4 weeks then weekly times 4 weeks to ensure code status is accurate to resident and/or RP preferences. Administrator and/or SW will complete a summary of audit results and present at the facility monthly QAPI meeting to ensure continues compliances.

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UNIVERSAL HEALTH CARE/FUQUAY-VARINA	410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526

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every 3 months during the care plan conference with the resident and family. The SW stated she missed Resident #12's orders during her 3-month review (occurred in March 2022) because she did not check the orders. She explained she only looked on the face sheet and care plan.

The facility Physician was interviewed by telephone on 6-16-22 at 2:30pm. The Physician explained he was unaware there had been an order written for Resident #12 to be a full code. He stated he would have expected the nurse to confirm with him the resident's code status so a conversation could have been arranged between himself, the family and the resident prior to any order being written.

An interview with the Administrator occurred on 6-17-22 at 4:58pm. The Administrator stated she expected the orders to have been reviewed but also for the nurse to have consulted with the physician, family and resident prior to writing the order.
2. Resident # 295 was admitted on 08/13/2021.

A review of Resident #295 ' s medical paper chart revealed a Do Not Resuscitate (DNR) order dated and signed by Resident #295 and the physician on 08/13/2021.

A review of a discharge summary from a recent hospital stay dated 09/02/2021 read, "full code."

A review of Resident #295 ' s care plan dated 09/02/2021 revealed he was cared planned to be a full code.

A review of the physician orders dated 09/21/2021, an order was written by Physician #1

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to "clarify code status" due to the documented change in Resident #295 ' s discharge summary.

A review of social worker #1 progress note dated 09/22/2021 revealed Resident #295 verified his wish to be of DNR status.

A review of Resident #295 ' s quarterly Minimum Data Set (MDS) dated 01/21/2022 revealed he was cognitively intact.

Interview with the facility ' s current Social Worker on 06/15/2022 at 10:34 am revealed she was not working at the facility at the time the clarification order was written for Resident #295 on 09/21/2021, however, the facility ' s process was to verify code status with the resident and/or families if a resident returns to their facility with a documented change in code status and update the care plan and electronic medical record.

Interview with Nurse Consultant #4 at 06/14/22 02:04 PM revealed the advance directive was not added in the electronic medical record for Resident #295. d Resident #295 ' s care plan was documented as a full code. Nurse Consultant #4 stated she reviewed the chart from her home and Resident 295 ' s last documented physician order in the hard chart dated 09/21/2021 was for DNR.

An interview with Physician #1 on 06/16/2022 at 2:25 pm revealed resident code status should always be documented in the electronic medical record as well as the hard chart medical record. Physician #1 also added if a resident ' s returns to the facility for any reason and the code status is different than what the facility has on record, the code status should always be verified with the

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F 578	Continued From page 14 resident or family representative.	F 578		
F 582 SS=C	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 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	F 582		7/15/22

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F 582	Continued From page 15 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 staff interviews and medical record review, the facility failed to provide a CMS-10055 (Centers for Medicare and Medicaid Services) Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) prior to discharge from Medicare part A services to two of two residents (Residents #63 and 88) sampled who remained in the facility and received non-covered services. Findings included: 1. Resident #63 was admitted to the facility under part A Medicare services on 12/28/21. A review of the medical record revealed a CMS-10123 Notice of Medicare Non-Coverage letter (NOMNC) was signed by Resident #63's responsible party on 3/8/22 . The notice indicated that Medicare coverage for skilled services were to end 3/10/22 and the resident would transition to long term care placement.	F 582	Social Worker and Business Office Manager educated on facility policy on advance beneficiary notification and notification of NOMNC by Reginal Business office Consultant on 07/14/2022. Resident #63 and resident rep. will be informed by 07/15/2022. Resident #88 and resident rep. will be informed by 07/15/2022. Social Worker and Business office manager educated on facility policy on advance beneficiary notification and notification of NOMNC by Reginal Business office Consultant on 07/14/2022. Business Office manager will audit chaffs	

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A review of the medical record revealed a CMS-10055 SNF ABN was not provided to the resident or responsible party.

An interview was completed with the Business Office Manager (BOM) on 6/17/22 at 4:53 PM. She stated she was unaware the SNF ABN was required, and the facility only issued the NOMNC. The BOM added that the facility had never used the ABN form when residents' Medicare part A services ended, and the resident remained in the facility with Medicare part A days remaining.

During an interview with the Corporate Clinical Director on 6/17/22 at 5:00 PM she stated the correct forms should have been completed for residents who were discharging from Medicare Part A services with days remaining. She reported the facility plans to provide training to staff involved with issuing the forms.

2. Resident #88 was admitted to the facility under part A Medicare services on 1/19/22.

A review of the medical record revealed a CMS-10123 Notice of Medicare Non-Coverage letter (NOMNC) was signed by Resident #88 on 2/22/22. The notice indicated that Medicare coverage for skilled services were to end 2/24/22 and the resident would transition to long term care placement.

A review of the medical record revealed a CMS-10055 SNF ABN was not provided to Resident #88.

An interview was completed with the Business Office Manager (BOM) on 6/17/22 at 4:53 PM.

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for the 30 days for residents that are still in the facility, were under part A Medicare and was issued a NOMNC and ensure that they were given a Skilled Nursing Facility Advanced Beneficiary Notice prior to discharge.

Social Worker audit Medicare part A discharges 5 times per week X 12 weeks, then monthly for 3 months. Results we be evaluated during IDT meeting the next day to ensure letter have been sent out.

Data collected during the audit will be analyzed for patterns, and trends and reprofiled to QAPI by the Social Worker monthly for 3 months. The QAPI committee will evaluate the effectiveness of the intervention to determine if to continue the auditing process is necessary to maintain compliance. Administrator will monitor

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F 582	Continued From page 17 She stated she was unaware the SNF ABN was required, and the facility only issued the NOMNC. The BOM added that the facility had never used the ABN form when residents' Medicare part A services ended, and the resident remained in the facility with Medicare Part A days remaining. During an interview with the Corporate Clinical Director on 6/17/22 at 5:00 PM she stated the correct forms should have been completed for residents who were discharging from Medicare Part A services with days remaining. She reported the facility plans to provide training to staff involved with issuing the forms.	F 582		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.	F 583		7/15/22

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F 583	Continued From page 18 §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to promote privacy for 2 of 2 residents when incontinent care was provided with the blinds open, and the facility failed to provide full visual privacy when Activity of Daily Living (ADL) care and was given and staff left the resident exposed with the blinds open (Resident #20 and Resident #25). Findings included: 1. Resident #20 was admitted to the facility on 3-21-22. The significant change Minimum Data Set (MDS) dated 6-4-22 revealed Resident #20 was cognitively intact. During an observation of Activities of Daily Living (ADL) care on 6-15-22 at 9:50am with Resident #20 and Nursing Assistant (NA) #1. Resident #20 was observed to be laying in her bed next to the window with the bed height even with the open blind exposed with only a brief on, her window blind was partially opened allowing	F 583	06/14/2022 the Director of Nursing educated CNA #2 and Unit Manager on residents rights, privacy and choices. The agency CNA's #2 contract was cancelled on 6/20/22. The agency was all so contacted and informed of the incident and the training Current residents are at risk for the same deficient practice. SDC and/or designee educated staff on residents rights, choices, and privacy beginning on 7/1/22 and completed on 07/15/2022. Newly hired and/or contracted staff will be educated during orientation. SDC and/or designee will audit/observe 10 residents daily 5X weekly for two weeks then 3X a week for 2 weeks, and 10 residents monthly for 2 months to ensure their rights are being respected to include their choices are being honored and privacy is being provided during care.	

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anyone walking by outside to see the resident exposed while the NA went into the bathroom to empty the water basin. Resident #20 was observed trying to cover herself with her hands because there were no sheets or blankets within her reach. The resident stated "I am so embarrassed. I wish she would have covered me." Resident #20 was observed to ask NA #1 to cover her, and the NA placed a new hospital gown on the resident.

NA #1 was interviewed on 6-15-22 at 10:00am. The NA stated she usually had made sure the blinds were closed and the resident was covered during ADL care, but she said when she was the only NA on hall 400, she had to hurry to try and get all her tasks completed and did not have time to think about the resident's dignity or privacy.

Resident #20 was interviewed on 6-15-22 at 1:45pm. The resident was observed sitting up in her wheelchair. The resident discussed feeling like no one cared about her and how that made her feel "awful".

During an interview with the Administrator on 6-17-22 at 4:58pm, the Administrator stated she expected staff to have the blinds closed and keep the resident covered as they provide ADL care.
2. Resident #25 was admitted to the facility 2/19/21.

The quarterly Minimum Data Set (MDS) revealed Resident #25 was cognitively impaired and required assistance with ADL's.

On 6/14/22 at 1:45PM incontinent care was observed on Resident #25 with Nursing Assistant #2 and the Unit Manager assisting. Resident #25

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Director of Nursing will audit data the audit will be analyzed for patterns, and trends and reported to QAPI by the Director of Nursing monthly for 3 months. The QAPI committee will evaluate the effectiveness of the intervention to determine if to continue the auditing process is necessary to maintain compliance. The Administrator will oversee the process.

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F 583	Continued From page 20 had a window in his room beside the head of his bed that looked out to a grassy area. Resident #25 was observed lying in bed with the bed raised approximately 3 feet. Resident #25 had a shirt on, no brief and the blinds on the window were open with a clear view to the outside allowing anyone who walked by to clearly see Resident #25 exposed. At 1:47 PM on 6/14/22 both the Unit Manager and NA #2 were interview. They both stated they would normally close the blinds but felt hurried. The Unit Manager stated the blinds should have been closed to provide dignity for Resident #25. During an interview with the Director of Nursing on 6/17/22 at 5:09 PM, she stated the blinds should be closed anytime a resident would be exposed to promote the resident's dignity.	F 583		
F 623 SS=C	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. (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.	F 623		7/15/22

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§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, 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;

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F 623	Continued From page 22 (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 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:	F 623		

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F 623	Continued From page 23 Based on record review and staff interviews the facility failed to provide written notice of discharge to the resident or the resident's representative for residents who were transferred to the hospital or 2 of 2 residents reviewed for facility-initiated discharge (Resident #86 and #92). The findings included: 1. Resident #86 was admitted to the facility on 5/20/22. Review of Resident #86 ' s records revealed she was sent to the hospital on 6/1/22. Review of Resident #86's medical record revealed no evidence that written notification of discharge was provided to the resident or resident representative for hospitalization on 6/1/22. She did not return to the facility. During an interview with the Social Services Director on 6/15/22 at 4:25 PM she stated she sent a list of discharges to the ombudsman monthly but did not send any written information regarding the discharge to the hospital to Resident #86 or her responsible party. She stated she was not aware that written notification needed to be provided for discharges to the hospital. An interview was conducted with the Administrator on 6/16/22 at 10:56 AM who stated the Social Services Director should have sent written notification of discharge to Resident #86 ' s responsible party. She further stated she started in her position as Administrator in April	F 623	On 5/20/2022 resident # 86 was admitted to facility on for short term rehabilitation. Resident # 86 received skilled nursing services from 05/20/2022 through 06/01/2022. Resident # 86 was sent to the hospital for change in condition on 06/20/2022 Case Manger from the hospital informed Admissions Director that resident wouldn't be retuning back to the facility. On 04/12/2022 Resident # 92 was admitted to facility on short term rehabilitation, Resident # 92 was sent to the hospital on 05/16/2022 for change in condition and was discharged from the facility on 05/17/2022. Resident returned to the facility on 05/26/2022 from the hospital due to improvement in condition. Resident discharged from the facility home on 07/01/2022. 100% audit will be done for the past 30 days on discharges/transfers to the hospital by the Social Worker starting on 06/01/2022. Director of Nursing educated on discharging/transferring residents from facility to the hospital and sending discharge notification by Reginal Director of Operations on 07/09/2022. Director of Nursing educated ADON, SDC, Unit Manager, and nursing department, including contract nursing staff, on discharging/transferring residents from the facility to the hospital and sending discharge notification on 07/09/2022 completion date 07/15/2022. Newly hired nursing staff will receive this	

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F 623	Continued From page 24 2022 and was in the process of providing some training to the Social Services Director. 2. Resident #92 was admitted to the facility on 4/12/22. Review of Resident #92 ' s records revealed she was sent to the hospital on 5/16/22. Review of Resident #92's medical record revealed no evidence that written notification of discharge was not provided to the resident or resident representative for hospitalization on 5/16/22. During an interview with the Social Services Director on 6/15/22 at 4:25 PM she stated she sent a list of discharges to the ombudsman monthly but did not send any written information regarding the discharge to the hospital to Resident #92 or her responsible party. She stated she was not aware that written notification needed to be provided for discharges to the hospital. An interview was conducted with the Administrator on 6/16/22 at 10:56 AM who stated the Social Services Director should have sent written notification of discharge to Resident #92 ' s responsible party. She further stated she started in her position as Administrator in April 2022 and was in the process of providing some training to the Social Services Director.	F 623	education during orientation, including contract nursing staff. Any one not receiving this education by 7/15/22, will not be allowed to work until education is completed. Administrator and/or designee will complete checks on 5 discharge residents 5x weekly x 2 weeks, 3x weekly times 2 weeks, weekly x1 week and weekly for 2 months then randomly x monthly, to ensure that proper discharge/transfer paperwork was completed and given to resident. Administrator will complete a summary of these audit results and present at the facility monthly QAPI, to ensure continued compliance.	
F 640 SS=B	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement-	F 640		7/15/22

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F 640	Continued From page 25 §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that	F 640		

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F 640	Continued From page 26 does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete and transmit the discharge Minimum Data Set for 2 of 2 residents reviewed for Resident Assessment (Resident #1 and Resident #2). Findings Include: 1. Resident #1 was discharged from the facility on 1/14/22. The discharge Minimum Data Set (MDS) dated 1/14/22 was signed by MDS Nurse #2 and the Social Worker on 6/13/22. On 6/17/22 at 8:30 AM an interview was conducted with the Social Worker, and she stated the assessment was overlooked and should have been completed when the resident was discharged. MDS Nurse #2 was interview on 6/17/22 at 10:07 AM and she stated the assessment was just missed. The Corporate Nurse Consultant #1 was interviewed on 6/17/22 at 5:04 PM and she stated the MDS should have been completed at discharge.	F 640	All residents that are discharging from the facility have the potential to be affected. The Regional MDS Consultant will audit 10 percent of quarterly assessments for the past 30 days and verify that all discharge assessment were completed. The MDS Nurse, and Social Worker was educated by the Reginal MDS coordinator on 07/01/2022. Education Coding, completing assessments on time for discharging residents. The MDS nurses were educated on making sure discharge assessments are completed on time. The Social Worker was educated by Social Worker from sister facility on 07/11/2022 on completing assessments for discharge residents on time. Checks will be completed By MDS Coordinator on 5 discharge residents 5x weekly then x 2 weeks, then 3x weekly then 2 weeks, weekly xl week then monthly x 2 monthly. Results we be evaluated during IDT meeting the next day and if done Friday, Saturday, and Sunday the IDT will review on Monday. Data collected during the audit will be	

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F 640	Continued From page 27 2. Resident #2 was discharged from the facility on 2/19/22. The discharge Minimum Data Set (MDS) dated 2/19/22 was sign by MDS Nurse #2 and the Social Worker on 6/13/22. On 6/17/22 at 8:30 AM an interview was conducted with the Social Worker, and she stated the assessment was overlooked and should have been completed when the resident was discharged. MDS Nurse #2 was interview on 6/17/22 at 10:07 AM and she stated the assessment was just missed. The Corporate Nurse Consultant #1 was interviewed on 6/17/22 at 5:04 PM and she stated the MDS should have been completed at discharge.	F 640	analyzed for patterns, and trends and reported to QAPI by the MDS Coordinator nurse monthly. The QAPI committee will evaluate the effectiveness of the intervention to determine if continuing the auditing process is necessary to maintain compliance. The Administrator will oversee the process.	
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 staff interviews and medical record review, the facility failed to code the Minimum Data Set (MDS) assessments accurately in the area of falls (Resident #87 and Resident #83). This was for 2 of 24 assessments reviewed. The findings included: 1. Resident #87 was admitted to the facility on	F 641	Residents #83 and #87 had the assessments modified and transmitted by the Minimum Data Set Nurse (MDS) to accurately reflect the coding of falls on 6/16/22. Current resident's minimum data sets were audited by the Regional Clinical Reimbursement Consultant on 6/16/22	7/15/22

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F 641

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4/22/22 with diagnoses that included dementia.

Review of Resident #87's medical record revealed a progress note dated 5/25/22 that detailed a fall with injury.

Resident #87's quarterly Minimum Data Set assessment with a date of 5/27/22 revealed no falls had been noted.

An interview was conducted with the MDS (Minimum Data Set) Nurse on 6/16/22 at 1:38 PM who stated she must have overlooked Resident #87 ' s fall and would do a correction.

An interview was conducted with the Administrator on 6/17/22 at 4:10 PM who stated Resident #87 had a fall and it should have been included on Resident #87's assessment.
2. Resident #83 was admitted to the facility on 8-3-17 with multiple diagnosis that included cerebral infarction

Review of the facility's falls revealed Resident #83 had sustained a fall on 2-10-22. The resident incident report documented the resident was found sitting on the floor in front of his wheelchair. The documentation showed the resident was assessed and did not have any injuries.

The quarterly MDS dated 2-22-22 that was reviewed on 6-15-22 revealed Resident #83 was severely cognitively impaired but was not coded for his fall on 2-10-22

During an interview with MDS Nurse #1 on 6-17-22 at 9:00am, the MDS nurse stated the 2-22-22 MDS assessment should have had Resident #83's fall coded and that it was an over

F 641

and 6/17/22 to ensure accurate coding of falls for the previous 60 days. Inaccuracies were modified/corrected and transmitted as determined necessary.

On 7/1/22 the Regional Clinical Reimbursement Consultant educated the MDS nurses on accurate coding of falls on the MDS assessments.

Falls will be reviewed during the clinical meeting by the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, MDS Nurses and Unit Managers to ensure all clinicians are aware of residents with falls.

The Director of Nursing, Assistant Director of Nursing/designee will audit the coding of minimum data sets to ensure accurate coding of falls for residents with falls weekly times 8 weeks then biweekly times two. Negative findings will be addressed with MDS Nurses and the minimum data set will be modified and transmitted as needed.

The Director of Nursing/designee will bring the results of all audits and the MDS nurses will bring copies of any necessary modifications to the monthly Quality Assurance Performance Improvement (QAPI) meeting for review by the QAPI Committee for patterns/trends for 3 months. The Committee will address negative findings. Additional interventions will be developed by the Committee and implemented by the Director of Nursing and MDS nurses as needed to sustain

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F 641	Continued From page 29 site. The Administrator was interviewed on 6-17-22 at 4:58pm. The Administrator stated she expected the MDS staff to code for falls if appropriate.	F 641	compliance.	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to refer a resident with new diagnoses of mental illness for a Level II Pre-Admission Screening and Resident Review (PASRR) for 1 of 1 resident reviewed for PASRR (Resident #71). The findings included: Resident #71 was admitted to the facility on	F 644	MDS (Minimum Data Set) Nurse completed a review of the current Minimum Data Set (MDS) for resident #87 and resident #83, on 06/16/2022 to ensure accuracy coding in the area of falls. An audit was completed by the regional MDS consultant and facility MDS nurse for	7/15/22

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02/10/2021 with a Level I PASRR determination.

Record review revealed Resident #71 was diagnosed with anxiety and psychotic disorder other than schizophrenia on 2/10/2022.

Resident #71 ' s annual Minimum Data Set (MDS) dated 2/10/2022 did not indicate they were currently considered by the state Level II PASRR process to have serious mental illness. Diagnoses included anxiety and psychotic disorder other than schizophrenia. The MDS also revealed there had been no behaviors, and they had received antipsychotic medications 5 out of 7 days and antidepressant medication 7 out of 7 days during the lookback period.

Resident #71 ' s care plan dated 4/22/2022 included a care plan for antipsychotic medication side effects and reduction interventions for combative behaviors.

In an interview on 6/15/2022 at 10:29 am, the facility ' s Social Worker stated she wasn ' t familiar with the PASRR process and stated the facility Administrator handled all PASRR information for the facility residents.

In an interview on 6/15/2022 at 10:43 am, the Administrator stated the facility should have initiated a Level II PASRR screening for Resident # 71 when the new diagnoses of anxiety and major depressive disorder was added on 2/10/2022.

F 644

the past 30 days of resident MDS, to verify that falls were coded correctly. Any discrepancies identified, the MDS assessment was corrected and transmitted on DATE 06/16/2022

The MDS nurses were educated by Reginal MDS Consultant accuracy of coding falls on 07/01/2022. If any inaccuracies are identified, they will be corrected, and additional training will be provided as warranted.
Audits for accuracy will be conducted by the Administrator, MDS nurse, and/or the Regional MDS consultant to include 25% of the fall assessments MDSs per week x 2 weeks, then 10% of the fall assessments MDSs per week x 4 weeks and continuing until the QAPI Committee determine had if the deficient practice is resolved.

Results of the audits will be recorded on an audit tool with the type of assessment, date of assessment and note any inaccuracies found. Inaccuracies will be corrected and the MDS resubmitted if needed. Any continued inaccurate coding of the MDS will result in corrective action. Administrator will ensure compliance. Inaccuracies will be corrected and the MDS resubmitted if needed. Any continued inaccurate coding of the MDS will result in corrective action. Administrator will ensure compliance. The results of the audit will be presented to the Quality Assurance Performance Improvement committee monthly by the MDS Nurse to ensure continued

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F 644	Continued From page 31	F 644	compliance.	
F 655 SS=C	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:	F 655		7/15/22

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(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews the facility failed to complete or formulate a baseline care plan within 48 hours and failed to provide a summary of the baseline care plans to residents or their representatives (Resident #14, Resident #86, Resident #87, and Resident #92) for 4 of 4 residents reviewed for baseline care plans.

The findings included:

1. Resident #14 was admitted to the facility on 3/4/22 with diagnoses that included hypertension, aphasia (a language disorder that affects the ability to comprehend and communicate) and hyperlipidemia. He was discharged from the facility on 5/24/22.

Review of Resident #14 ' s baseline care plan revealed an undated baseline care plan with incomplete areas for communication, discharge planning and social services. There was no documented evidence that a written summary of the baseline care plan was given to Resident #14 or his representative.

An interview was completed with the Regional Corporate Nurse Consultant on 6/16/22 at 11:29 AM who stated the baseline care plan for Resident #14 was not complete.

F 655

The facility failed to complete or formulate a baseline care plan within 48 hours and failed to provide a summary of the baseline care plan to the residents or their representatives (resident #14, resident #86, resident #92)

Resident #86 discharged home 07/01/2022

Resident # 14 discharged home 05/30/2022

Resident # 86 discharged home 07/01/2022

All newly admitted residents are required to have a baseline care plan with 48 hours of admission and copy given to resident and/representatives during the 72-hour care conferences. Accordingly, all residents are at risk of not having a baseline care plan upon admission. Director of Nursing and or Assisted director of nursing will audit new admissions for the past 30 days. Ok any baseline care plan found to be missing or incomplete will be prepared by the interdisciplinary team. For residents in the

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An interview was conducted with the MDS Nurse on 6/16/22 at 1:38 PM who stated that the admitting nurse was responsible for initiating the baseline care plan. She reported the baseline care plans were taken to morning meeting and any discipline that had not completed their area of the care plan were to complete it at that time. She further stated she was unsure who was responsible to provide a summary of the baseline care plan to residents or their representatives.

During an interview with the Director of Nursing on 6/16/22 at 1:40 PM she stated the baseline care plan summary process was in development and she was aware of the issue. She stated a written summary of the baseline care plan was not provided to Resident #14 or his responsible party.

2. Resident #86 was admitted to the facility on 5/20/22 with diagnoses that included diabetes mellitus and chronic kidney disease. She was discharged from the facility on 6/1/22.

Review of Resident #86 ' s baseline care plan revealed an undated baseline care plan with incomplete areas for communication, medications, social services, and discharge planning. There was no documented evidence that a written summary of the baseline care plan was given to Resident #86 or her representative.

An interview was completed with the Regional Corporate Nurse Consultant on 6/16/22 at 11:29 AM who stated the baseline care plan for Resident #86 was not complete.

An interview was conducted with the MDS Nurse

F 655 (Plan of Correction)

facility and social worker and director of nursing will review the results with the residents and/or POA.

Accordingly, all residents are at risk of not having a baseline care plan upon admission. The Director of Nursing and or Assisted director of nursing will audit all new admissions for the past 30 days. If any baseline care plans are found to be missing or incomplete one will be prepared by the interdisciplinary team for residents in the facility. The Social Worker and the clinical nursing team will review the baseline care plan with the resident and/or resident representative; a copy will be given to them.

Education provided by Reginal Reimbursement Nurse on 07/01/2022 Upon resident admission, the baseline care plan will be initiated by the admitting nurse. The facility interdisciplinary team (IDT) After baseline care is reviewed/finalized, the baseline care plan will be reviewed with the resident and/or RP and copy given during the care conferences.

Upon resident admission, the baseline care plan will be initiated by the admitting nurse. The facility interdisciplinary team (IDT) which includes the director of nursing, MDS nurse, Social Work, activities director, dietary manager, will review the baseline care plan for accuracy. After baseline care is reviewed/finalized, the baseline care plan will be reviewed with the resident/RP and

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F 655	Continued From page 34 on 6/16/22 at 1:38 PM who stated that the admitting nurse was responsible for initiating the baseline care plan. She reported the baseline care plans were taken to morning meeting and any discipline that had not completed their area of the care plan were to complete it at that time. She further stated she was unsure who was responsible to provide a summary of the baseline care plan to residents or their representatives. During an interview with the Director of Nursing on 6/16/22 at 1:40 PM she stated the baseline care plan summary process was in development and she was aware of the issue. She stated a written summary of the baseline care plan was not provided to Resident #86 or her responsible party. 3. Resident #87 was admitted to the facility on 4/22/22 with diagnoses that included hypertension and dementia. Review of Resident #87 ' s baseline care plan revealed an undated baseline care plan with incomplete areas for activities of daily living and social services. There was no documented evidence that a written summary of the baseline care plan was given to Resident #87 or her representative. An interview was completed with the Regional Corporate Nurse Consultant on 6/16/22 at 11:29 AM who stated the baseline care plan for Resident #87 was not complete. An interview was conducted with the MDS Nurse on 6/16/22 at 1:38 PM who stated that the admitting nurse was responsible for initiating the baseline care plan. She reported the baseline care plans were taken to morning meeting and	F 655	copy given during the 72-hour care conferences. The MDS Coordinator will audit the new admissions for baseline care plans weekly x4 monthly x2. Results of the audit will be presented to the Quality Assurance Committee by DON. Audits will continue for 3 months or until the QAPI Committee determines the deficient practice is resolved. Administrator will ensure compliance.	

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F 655	Continued From page 35	F 655		

any discipline that had not completed their area of the care plan were to complete it at that time. She further stated she was unsure who was responsible to provide a summary of the baseline care plan to residents or their representatives.

During an interview with the Director of Nursing on 6/16/22 at 1:40 PM she stated the baseline care plan summary process was in development and she was aware of the issue. She stated a written summary of the baseline care plan was not provided to Resident #87 or her responsible party.

4. Resident #92 was admitted to the facility on 4/12/22 with diagnoses that included dementia and hypertension.

Review of Resident #92 ' s medical record revealed a baseline care plan dated 4/12/22 which documented with incomplete areas for activities of daily living and social services. There was no documented evidence that a written summary of the baseline care plan was given to Resident #92 or her representative.

An interview was completed with the Regional Corporate Nurse Consultant on 6/16/22 at 11:29 AM who stated the baseline care plan for Resident #92 was not complete.

An interview was conducted with the MDS Nurse on 6/16/22 at 1:38 PM who stated that the admitting nurse was responsible for initiating the baseline care plan. She reported the baseline care plans were taken to morning meeting and any discipline that had not completed their area of the care plan were to complete it at that time. She further stated she was unsure who was

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F 655	Continued From page 36 responsible to provide a summary of the baseline care plan to residents or their representatives. During an interview with the Director of Nursing on 6/16/22 at 1:40 PM she stated the baseline care plan summary process was in development and she was aware of the issue. She stated a written summary of the baseline care plan was not provided to Resident #92 or her responsible party.	F 655		
F 657 SS=E	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 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	F 657		7/15/22

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F 657	Continued From page 37 comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, and staff interviews, the facility failed to review and revise the care plan in the areas of behavior (Resident #92), splints (Resident #74), code status (Resident #295), care plan revision (Resident #59) and care plan development (Resident #94) This was for 5 of 38 residents reviewed. The findings included: 1. Resident #92 was admitted to the facility on 4/12/22 with diagnoses that included dementia and hypertension. Resident #92 ' s most recent Minimum Data Set assessment completed on 5/31/22, a quarterly assessment revealed she was coded for no behaviors. Resident #92's active care plan, last reviewed 5/31/22, included a focus area for socially disruptive behaviors (yelling while walking in the hallway and in room). A review of Resident #92 ' s progress notes since admission revealed no documentation of socially disruptive behaviors. An interview was conducted with Nurse Aide #5 who stated she was familiar with Resident #92 and stated she has not had any disruptive behaviors. During an interview with the MDS Nurse on 6/16/22 at 1:38 PM she stated the focus area for	F 657	The care plans for the following residents were reviewed and revised to accurately reflect the resident. Resident #92 for behaviors and #74 for splinting. Resident's # 59 and #94 care plans were reviewed and revised by the Interdisciplinary Team. Resident #295 is expired therefore no review or changes made. Starting 7/5/22 Care Plans for the current residents were reviewed for required updates by the Interdisciplinary Team to include: The Director of Nursing and Administrative Nurses, Minimum Data Set (MDS) Nurses, Social Worker and Dietary. The updates will be completed by 7/15/22. The Regional Clinical Reimbursement Consultant educated the Interdisciplinary Team on the process/policy for care planning on 7/11/22. The Director of Nursing/designee and MDS nurses will audit the care plans according to the MDS assessment schedule weekly times 4 weeks and bimonthly times 2 months. Care plan inaccuracies will be revised/corrected as determined necessary by the IDT. The MDS Nurses will bring the results of all audits to the monthly Quality Assurance Performance Improvement	

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F 657	Continued From page 38 socially disruptive behaviors on Resident #92 ' s care plan was an error. She stated Resident #92 had not had any socially disruptive behaviors. The Director of Nursing was interviewed on 6/16/22 at 1:40 PM and indicated it was her expectation for the care plan to be an accurate representation of the resident. 2. Resident #74 was admitted to the facility on 4-16-19 with multiple diagnosis that included bilateral contractures of elbows. Physician order dated 5-7-22 revealed Resident #74 to have elbow splints applied to his left and right elbows up to 4 hours a day. Apply left elbow splint at 12:00pm until 4:00pm, remove and apply right elbow splint from 4:00pm to 8:00pm then remove. The quarterly Minimum Data Set (MDS) dated 5-12-22 revealed Resident #74 was severely cognitively impaired with no mood or behavior problems coded. Resident #74's care plan dated 6-13-22 revealed no goal or interventions for his bilateral elbow splints. During an interview with the MDS Nurse #1 on 6-17-22 at 2:07pm, the MDS nurse stated there was not any goals or interventions for Resident #74's elbow splints. She stated she did not know why there was not any goals or interventions and said she thought she had added them on the 6-13-22 review.	F 657	(QAPI) meeting for review by the QAPI Committee for patterns/trends for 3 months. The Committee will address negative findings. Additional interventions will be developed by the Committee and implemented by Interdisciplinary Team as needed to sustain compliance. Administrator will monitor	

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F 657	Continued From page 39 The Administrator was interviewed on 6-17-22 at 4:58pm. The Administrator stated she expected care plans to have goals and interventions listed that are relevant to the resident's needs. 3. Resident # 295 was admitted to the facility on 08/13/2021 with diagnoses which included multiple sclerosis, atrial fibrillation, hypertension, and chronic obstructive pulmonary disease (COPD). A review of Resident #295 ' s medical record revealed a Do Not Resuscitate (DNR) order dated and signed by Resident #295 and the physician on 08/13/2021. A review of Resident #295 ' s quarterly Minimum Data Set (MDS) dated 01/21/2022 revealed he was cognitively intact. A review of Resident #295 ' s care plan dated 04/02/2022 revealed a full code care plan had been initiated on 09/02/2021. An interview with the facility ' s Social Worker on 06/15/2022 at 10:34 am revealed care plans should be updated at least every three months or when there is a change in status for a resident. Interview with the Director of Nursing (DON) on 06/16/2022 at 11:22 am revealed Resident #295 ' s care plan should have been updated on 09/22/2021 when the code status was verified as DNR by Resident #295. An interview with the Administrator on 06/16/2022 at 3:32 pm revealed care plans should be revised and updated as changes occur and reviewed by the Interdisciplinary Team (IT) at least every three months.	F 657		

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4. Resident #59 was admitted to the facility 6/13/20 with diagnoses including depression and cognitive communication deficit.

Resident #59 was care planned for extensive/total assistance with Activities of Daily Living, risk for skin breakdown, long term care, advance directives, pain, abnormal bleeding, mood and behaviors, safety, medication side effects, skin breakdown, and impaired cognition. All care plans were initiated in June 2021 with review dates in October 2021. Care plans for weight loss and antidepressant use were initiated June 2021 with a review date of 10/30/21.

The Annual Minimum Data Set (MDS) was completed for Resident #59 on 2/9/22.

Record review revealed a care conference had been conducted regarding Resident #59 on 3/30/22.

A Quarterly MDS was completed on 5/2/22.

On 6/17/22 at 12:20 PM an interview with MDS Nurse #1 was conducted. She stated care plan meetings take place once a quarter, but the MDS nurses do not attend those meetings. She stated when the MDS nurses do an assessment, the care plans are updated/reviewed at that time. During the interview, MDS Nurse #1 was observed looking at Resident #59 ' s care plans and she stated they had not been updated/reviewed.

An interview with Nurse Consultant #2 was conducted on 6/17/22 at 4:57 PM. She stated care plans should be reviewed/updated within 7

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F 657	Continued From page 41	F 657		

days after an assessment and in between assessments if needed.

5. Resident #94 was admitted to the facility on 05/23/2022 with a diagnosis of left hip fracture.

A review of the comprehensive admission Minimum Data Set (MDS) assessment for Resident #94 dated 05/28/2022 revealed she was cognitively intact. She required the extensive assistance of one person for bed mobility, toileting, personal hygiene, and bathing. She was at risk for pressure ulcers. She had 1 unstageable pressure ulcer present on admission. She had a pressure relieving device to her bed and pressure ulcer care in place. It further revealed the Care Area Assessment (CAA) summary for this assessment included triggered areas of communication, activities of daily living, urinary incontinence, falls, nutritional status, pressure ulcer and pain which would be addressed in her care plan.

On 06/16/2022 a review of the medical record for Resident #94 revealed no comprehensive care plan had been developed.

On 06/17/2022 at 9:32 AM a telephone interview with MDS Nurse #2 indicated she completed the comprehensive MDS assessment for Resident #94 dated 05/28/2022. She stated Resident #94 did not have a comprehensive care plan in place. She went on to say Resident #94 should have had a comprehensive care plan completed with 7 days of the completion of her comprehensive MDS assessment. MDS Nurse #2 stated she had no explanation for this other than she just missed it.

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F 657	Continued From page 42 On 06/17/2022 at 2:40 PM an interview with the Administrator indicated Resident #94 should have had a comprehensive care plan developed within 7 days of the completion of her comprehensive MDS assessment.	F 657		
F 661 SS=B	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 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	F 661		7/15/22

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F 661	Continued From page 43 by: Based on record review and staff interviews the facility failed to complete a recapitulation of stay for 2 of 2 residents reviewed for a planned discharge from the facility (Resident #14 and #81). The findings included: 1. Resident #14 was admitted to the facility on 3/4/22 with diagnoses that included hypertension and hyperlipidemia. He was discharged from the facility on 5/24/22 to the community. Resident #14's admission Minimum Data Set assessment dated 3/10/22 coded him as having a moderate cognitive impairment and having the expectation to be discharged to the community. Review of Resident #14's record revealed he was discharged home on 5/24/22. Further review revealed no evidence the facility completed a recapitulation of Resident #14's stay in the facility. The facility Social Worker stated during an interview on 6/14/22 at 4:25 PM she was not aware who was responsible for completing the recapitulation of Resident #14's stay in the facility. An interview was conducted with the Administrator on 6/15/22 at 10:56 AM who stated the facility Social Worker was responsible for completing the recapitulation of Resident #14's stay in the facility. The Administrator stated she came to the facility in April 2022 and had identified some areas such as discharge planning that required some additional training. She stated the Social Worker had been with the facility since	F 661	1) How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #14 and #81 no longer resides in the facility 2) How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected the alleged deficient practice. 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: All members of the Interdisciplinary team (IDT), including the facility social services director and executive director, have received training from the regional clinical nurse, on the completion of the recapitulation of a discharge summary for residents at time of discharge. This training was completed on 07/01/2022 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained Social Worker and/or designee will complete weekly audits for 5 days for 4 weeks, then monthly of 3 months and then quarterly, of resident□s medical records to ensure that at the time of discharge there is a completed recapitulation of a residents stay, to	

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F 661	Continued From page 44 September 2021. 2. Resident #81 was admitted to the facility on 3/25/21 with diagnoses that included anemia. She was discharged to another facility on 6/9/22. Resident #81 ' s quarterly Minimum Data Set assessment dated 5/17/22 coded her as having a moderate cognitive impairment. Review of Resident #81 ' s medical record revealed she was discharged to another facility on 6/9/22. Further review revealed no evidence the facility completed a recapitulation of Resident #81 ' s stay in the facility. The facility Social Worker stated during an interview on 6/14/22 at 4:25 PM she was not aware who was responsible for completing the recapitulation of Resident #14's stay in the facility. The facility Social Worker stated during an interview on 6/14/22 at 4:25 PM she was not aware who was responsible for completing the recapitulation of Resident #81's stay in the facility. An interview was conducted with the Administrator on 6/15/22 at 10:56 AM who stated the facility Social Worker was responsible for completing the recapitulation of Resident #81's stay in the facility. The Administrator stated she came to the facility in April 2022 and had identified some areas such as discharge planning that required some additional training. She stated the Social Worker had been with the facility since September 2021.	F 661	include but not limited to, diagnosis, course of illness/treatment or therapy, and pertinent lab, radiology and consultations results. The Social Worker and/or designee will complete a summary of audit results and present at the facilities monthly QAPI meeting to ensure continued compliance.	
F 677 SS=G	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677		7/15/22

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F 677	Continued From page 45 §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, observation, resident and staff interviews the facility failed to provide incontinence care and showers for 2 of 2 dependent residents (Resident #20 and Resident #8) reviewed for Activities of Daily Living (ADL) care. Resident #20 voiced feeling "awful" and that staff did not care about her. Resident #8's scrotum and buttocks were bright red and Resident #8 voiced pain when his scrotum and buttocks was cleaned. The Nursing Assistant (NA) #9 applied protective barrier cream to Resident #8's scrotum and buttocks. Findings included: 1.Resident #20 was admitted to the facility on 3-21-22 Resident #20's care plan dated 3-28-22 revealed a goal that she would maintain her level of care needs. The interventions for the goal were in part resident requires assistance from staff for bathing, grooming and incontinence care. The significant change Minimum Data Set (MDS) dated 6-4-22 revealed Resident #20 was cognitively intact requiring assistance with 2 people for bed mobility, transfers, toileting, personal hygiene and bathing, one persona assist for dressing. There were no behaviors coded on the MDS. Review of Resident #20's ADL care	F 677	Resident #20 and #8 received ADL and incontinent care by the CNA on 06/15/2022. Barrier Cream was applied to Resident #8 post care. Current residents have the potential to be affected by the same deficient practice: Current nursing staff, including contract nursing staff, will be educated regarding the expectations of residents receiving bath/showers according to the shower schedule and to receive timely incontinent care and what to do when a resident refuses this care. This education was provided by the Director of Nursing/Staff Development Coordinator/designee on 7/5/22. Newly hired nursing staff, including contract nursing staff will receive this education during orientation. The Nurse Managers will audit the weekly shower/bath schedules to ensure that residents are receiving showers as scheduled per their preference. Audits will be conducted daily five times a week for 2 weeks, twice a week for 2 weeks and then weekly for 2 months. Negative findings will be addressed when/if noted. The Social Worker will conduct interviews of five alert/oriented residents weekly for 12 weeks regarding whether residents are	

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F 677 Continued From page 46

documentation revealed no documentation that she had received a shower/bed bath for the following dates:

-April 2022: 4-1-22 through 4-5-22, 4-8-22 through 4-11-22, 4-13-22 through 4-17-22, 4-19-22 through 4-27-22, 4-29-22 and 4-30-22.

-May 2022: 5-1-22 through 5-4-22, 5-6-22 through 5-13-22, 5-15-22 through 5-18-22, 5-20-22 through 5-25-22, 5-27-22 through 5-30-22.

-June 2022: 6-1-22 through 6-5-22, 6-9-22 through 6-11-22 and 6-13-22.

Review of Physician orders from April 2022 through June 2022 revealed Resident #20 was not ordered a diuretic (medication to increase urine output).

Resident #20 was interviewed on 6-13-22 at 10:15am. The resident discussed not receiving a bath daily. She stated the staff tell her they were short staffed and did not have time to provide a bath. Resident #20 also discussed issues with having to wait to receive incontinence care and specified she had looked at her clock on her over the bed table and had to wait over 2 hours. The resident said this made her feel like no one cared about her and that she felt "awful".

Observation of ADL care for Resident #20 occurred on 6-15-22 at 9:50am with Nursing Assistant (NA) #1. Resident #20's brief was observed to be saturated with urine that had soaked through to the under pad on the bed and her sheet. Resident #20's skin was noted to be intact.

F 677

receiving bed baths/showers as scheduled and timely incontinent care.

The Social Worker will take the results of all audits to the Quality Assurance Performance Improvement meeting for review by the committee for 3 months. Additional interventions will be developed and implemented as determined necessary by the committee to sustain substantial compliance.

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F 677	Continued From page 47 During an interview with NA #1 on 6-15-22 at 10:00am, NA #1 stated Resident #20's brief was saturated and said she had not been able to check or provide incontinence care to Resident #20 prior to 9:50am and did not know when night shift had last provided incontinence care to Resident #20. She explained she was the only NA for hall 400 (part of station 2 with approximately 14 residents) and could not check or provide incontinence care every 2 hours to her assigned residents. NA #1 also stated she would not be providing a bed bath or shower to all her assigned residents today (6-15-22). A telephone interview occurred with NA #7 on 6-16-22 at 10:47am. NA #7 confirmed she had worked with Resident #20 on the 11:00pm to 7:00am shift the night of 6-14-22. The NA stated she had last provided incontinence care to Resident #20 between 6:00am and 6:30am. An interview with NA #8 occurred on 6-16-22 at 12:34pm. NA #8 discussed working with Resident #20 on 5-21-22. She recalled being the only NA on hall 400 that day and assigned to approximately 14 residents. She explained on 5-21-22 Resident #20 had refused a bed bath when the NA was available to provide a bed bath. NA #8 stated she did not have time to go back and provide a bed bath when the resident requested so she said Resident #20 did not receive a bed bath on 5-21-22. NA #9 was interviewed on 6-16-22 at 1:43pm. NA #9 stated she had been assigned to Resident #20 on 6-5-22 but could not remember if she had provided a bed bath to the resident. She explained it was a weekend and she was the only	F 677		

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NA assigned to hall 400 and said, "so I might not have".

A telephone interview occurred with NA #10 on 6-16-22 at 3:25pm. NA #10 discussed being assigned to Resident #20 on 4-10-22. She discussed 4-10-22 being a weekend and stated the facility had been short staffed so she was not able to provide a bed bath to Resident #20.

The Administrator was interviewed on 6-17-22 at 4:58pm. The Administrator stated she expected staff to check on their assigned residents at least every 2 hours and stated the staff should be checking their assigned residents at the start of their shift for incontinence. She also added the facility had not been short staffed.

2. Resident #8 was admitted to the facility on 4-22-21

Resident #8's care plan dated 3-6-22 revealed a goal that he would be clean, dry, appropriately dressed and maintain his level of care. The interventions for the goal were in part resident requires assistance of staff with bathing, dressing, grooming, oral care and incontinence care.

The quarterly Minimum Data Set (MDS) dated 6-14-22 revealed Resident #8 was severely cognitively impaired with no mood or behaviors. He was coded as needing total assistance with 2 people for bed mobility and transfers, total assistance with one person for toileting, personal hygiene and bathing.

Review of Physician orders revealed Resident #8 was not ordered a diuretic (medication to

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F 677	Continued From page 49	F 677		

increase urine output.).

Observation of Activities of Daily Living (ADL) care for Resident #8 occurred on 6-16-22 at 9:30am with Nursing Assistant (NA) #9. Resident #8's brief was noted to be saturated with urine through to the under pad on the bed. The resident's scrotum was noted to be bright red and when the NA wiped the scrotum area Resident #8 said "ow". Further observation of Resident #8's skin revealed his buttocks was also bright red. No open skin areas were observed, and NA #9 was observed to apply protective barrier cream to Resident #8's scrotum and buttocks.

During an interview with NA #9 on 6-16-22 at 9:45am, the NA commented how saturated Resident #8's brief was and the redness to his scrotum and buttocks. She stated she would inform the nurse of the redness. NA #9 discussed not checking the resident prior to 9:30am for incontinence care and stated she did not have time before the breakfast trays were delivered because she was the only NA for hall 400 (part of station 2 with approximately 14 residents). She also said she was not aware when the last time Resident #8 had incontinence care provided.

A telephone interview occurred with NA #11 on 6-16-22 at 3:32pm. NA #11 confirmed she had been assigned to Resident #8 from 7:00pm to 7:00am on 6-15-22. She stated she had last provided incontinence care to Resident #8 at approximately 5:30am on 6-16-22.

The Administrator was interviewed on 6-17-22 at 4:58pm. The Administrator stated she expected staff to check on their assigned residents at least every 2 hours and stated the staff should be

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F 677	Continued From page 50 checking their assigned residents at the start of their shift for incontinence.	F 677		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff, family and physician interviews the facility failed to complete a full body skin assessment on admission to accurately identify any pressure related injury present and failed to implement treatment orders for a left heel deep tissue injury (DTI) identified by the facility as present on admission. This placed Resident #94 at risk for worsening of her left heel DTI. This was for 1 of 4 residents reviewed for pressure ulcers. (Resident #94) Findings included: Resident #94 was admitted to the facility on 05/23/2022 with a diagnosis of left hip fracture.	F 686	Resident #94 wound was assessed on 6/16/2022 by the facility treatment nurse. Treatment was appropriate for wound. A review of the last 30 days of admission was audited, by the Director of Nursing and Administrative Nurses, for skin assessments on admission with treatments within 24 hours, initiated. No further discrepancies were found during the audit. All residents will receive a skin assessment within 24 hours of admission and if an area is identified, the licensed nurse will initiate a treatment. Clinical staff, including contract nursing staff were	7/15/22

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A review of the hospital discharge summary for Resident #94 dated 05/23/2022 did not reveal any evidence of DTI or other pressure related injury to her heels.

A nursing admission assessment for Resident #94 dated 05/23/2022 at 6:57 PM revealed Nurse #8 assessed Resident #94 as at moderate risk for pressure ulcers. It further revealed documentation by Nurse #8 that Resident #94 had no skin conditions.

A nursing progress note dated 05/23/2022 at 7:14 PM written by Nurse #8 revealed Resident #94 arrived on the unit at approximately 2:24 PM. She had dressings intact to her bilateral heels on admission. She denied any pain or other concerns.

A nutrition progress note for Resident #94 dated 05/25/2022 at 6:15 PM revealed Resident #94 was receiving a regular diet with a fortified nutritional supplement three times daily and vitamin supplementation.

A review of the May 2022 physician orders for Resident #94 revealed an order dated 05/24/2022 for a pressure reducing device to her bed. An order dated 05/28/2022 revealed she was admitted to hospice on 05/27/2022.

A review of the comprehensive admission Minimum Data Set (MDS) assessment for Resident #94 dated 05/28/2022 revealed she was cognitively intact. She required the extensive assistance of one person for bed mobility, toileting, personal hygiene, and bathing. She was at risk for pressure ulcers. She had 1 unstageable pressure ulcer present on

in-serviced on 7/5/22 and on skin assessment and how to initiate treatments if wounds identified, within the first 24 hours. Newly hired clinical staff, including contract nursing staff will receive this education during orientation. Licensed nurses who did not receive this training by 7/15/22, will not be allowed to work until training completed.

Admissions will be reviewed Monday-Friday in the clinical meeting and audited for skin assessment and ordered treatment if necessary. Director of nursing or designee will review 5 residents TARs for compliance daily Monday thru Friday X 12 weeks.
The Director of Nursing/designee will bring the results of all audits to the monthly Quality Assurance Performance Improvement (QAPI) meeting for review by the QAPI Committee for patterns/trends for 3 months. The Committee will address negative findings. Additional interventions will be developed by the Committee and implemented by the Director of Nursing, Assistant Director of Nursing/designee as needed to sustain compliance. Administrator will monitor

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F 686	Continued From page 52 admission. She had a pressure relieving device to her bed and pressure ulcer care in place. It further revealed the Care Area Assessment (CAA) summary for this assessment included triggered areas of communication, activities of daily living, urinary incontinence, falls, nutritional status, pressure ulcer and pain which would be addressed in her care plan. A treatment order dated 05/29/2022 indicated to apply skin prep to her left heel twice daily for a DTI. A physician's treatment order dated 05/29/2022 indicated to float Resident #94's heels while she was in bed. There were no physician's treatment orders for Resident #94's left heel prior to 05/29/2022. On 06/13/2022 at 11:57 AM an observation of Resident #94 revealed she was in bed. She had a pressure relieving air mattress in place which was functioning. Her heels were floated. She denied having any skin issues or wounds. A review of the medical record for Resident #94 on 06/16/2022 revealed no comprehensive care plan was in place. On 06/16/2022 at 6:16 PM a telephone interview with Nurse #8 indicated she did not recall Resident #94. She stated she typically would do a full body skin assessment on a newly admitted resident which would include removing any dressings present to assess the skin underneath and document any skin conditions she found. She stated if there was no documentation that she removed Resident #94's heel dressings to assess the skin under them to determine if her heels had any breakdown or needed any treatments then she could not say whether she had done it or not.	F 686		

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F 686	Continued From page 53 Multiple attempts to conduct telephone interview with the Nursing Assistant (NA) caring for Resident #94 on 05/23/2022 and 05/24/2022 were unsuccessful. On 06/16/2022 at 10:27 AM an interview with Nurse #9 indicated she was Resident #94's hospice nurse. She stated Resident #94 had her first admission visit to hospice on 05/27/2022. She went on to say Resident #94's initial hospice visit would not have included a skin assessment. Nurse #9 further indicated Resident #94's second hospice visit on 05/29/2022 included a full body skin assessment. She stated on 05/29/2022 Resident #94 was assessed as having a left heel DTI. She went on to say the area had been soft with purple non blanchable skin. She further indicated her understanding was this DTI was present on Resident #94's admission to the facility. Nurse #9 indicated she initiated standing wound treatment orders on 05/29/2022 for skin prep (a protective wipe) to the area twice daily and for floating Resident #94's heels while she was in bed. She stated she began weekly measurements and monitoring of this area on 05/29/2022 and the facility was doing the daily treatments. Nurse #9 went on to say her measurement of Resident #94's left heel DTI today indicated it was 4.4 centimeters (cm) in length and 4 cm in width. She stated there was no depth and the area was not open. She went on to say the area was unchanged from her previous weekly measurements. She stated Resident #94 would not be seen by the wound care physician per her and her family's request. She went on to say while it was not likely that this area would heal due to Resident #94's immobility and decreased nutritional intake, the goal was to prevent it from worsening and to keep Resident	F 686		

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#94 comfortable.

On 06/16/2022 at 11:16 AM an interview with the Director of Nursing (DON) indicated she was familiar with Resident #94. She stated Resident #94 was admitted to the facility on 05/23/2022 with the DTI to her left heel. She stated Nurse #8 had not done a thorough admission skin assessment for Resident #94. She went on to say all residents should have a complete head to toe skin assessment done on admission to the facility which included removing any dressings present to assess the skin underneath. The DON stated if skin issues were found, these should be accurately documented with measurements and a description. She went on to say the facility had standing orders for wounds, including for DTI. She stated Nurse #8 should have initiated these standing orders and begun treatment to Resident #94's left heel DTI immediately. She further indicated if Nurse #8 had not felt the standing orders were appropriate, she should have contacted the physician. She stated Resident #94 had not received any treatment for her left heel DTI until 6 days after admission. She further indicated this placed Resident #94 at risk for worsening of her DTI.

On 06/16/2022 at 2:50 PM a telephone interview with Resident #94's family member indicated Resident #94 had been in the hospital for 2 weeks prior to her admission to the facility. She stated Resident #94 had been complaining of pain to her left heel while she was in the hospital. She stated while she did not know the specifics regarding Resident #94's left heel, she did know there had been an area that was being treated with skin prep prior to Resident #94's admission to the facility.

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F 686	Continued From page 55 On 06/16/2022 at 2:45 PM a telephone interview with Physician (MD) #1 indicated Resident #94 had a left heel DTI present on admission to the facility. He stated she should have received a head to toe skin assessment on admission to the facility. He stated this would include removing any dressings which were present to assess the skin underneath. He further indicated the facility had standing wound care orders. MD #1 stated these should have been immediately implemented for Resident #94 unless the nurse did not think they were appropriate in which case the nurse should have contacted him for further guidance.	F 686		
F 688 SS=E	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 observations, record review and	F 688	Facility failed to apply bilateral elbow	7/15/22

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F 688	Continued From page 56 resident, staff and physician interview the facility failed to apply bilateral elbow splints and a left-hand splint as ordered by the physician for 2 of 2 residents (Resident #74 and Resident #46) reviewed for positioning and mobility. Findings included: 1.Resident #74 was admitted to the facility on 4-16-19 with multiple diagnosis that included bilateral contractures of the left and right elbows. Physician order dated 5-7-22 revealed the following order: apply elbow splints to left and right elbows up to 4 hours each. Apply left elbow splint for 4 hours starting at 12:00pm and remove at 4:00pm. Apply right elbow splint for 4 hours starting at 4:00pm and removing at 8:00pm daily. The quarterly Minimum Data Set (MDS) dated 5-12-22 revealed Resident #74 was severely cognitively impaired. Review of Resident #74's Treatment Administration Record (TAR) for May 2022 and June 2022 revealed no documentation of the resident's elbow splints being applied. Resident #74's care plan dated 6-13-22 revealed no goals or interventions for his elbow splints. During an observation of Resident #74 on 6-14-22 at 1:15pm, Resident #74 was observed not to be wearing his elbow splint. Observation of Resident #74 on 6-14-22 at 6:00pm revealed he was not wearing his elbow splint. During an observation of Resident #74 on	F 688	splints and a left-hand splint as ordered by the physician. All current residents with splints orders were verified with occupational therapy and MD. This audit was completed 7/1/2022. Resident #1 Discharge from facility 01/14/2022 Resident # 46 was referred to therapy 07/09/2022 Director of Nursing, Assistant Director of Nursing, and unit managers and designee will educate licensed nurses to place orders in electronic medical records. This education will be completed by 7/14/2022 and on new hire. Conduct a facility tour to identify anyone needing splint application. Anyone identified will be referred to therapy for proper intervention. 07/13/2022 and on new hire all nursing staff will be educated by the DON or designee to apply splints as ordered and report new identified issues loss of ROM. Effective 07/13/2022 administrative nurses will audit 5 residents 5x weekly x 2 weeks, 3x weekly times 2 weeks, weekly x1 week and weekly for 2 months Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing monthly X 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing will be	

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6-15-22 at 2:00pm, Resident #74 was in the bed resting with no elbow splint present.

The facility's Rehabilitation Director was interviewed on 6-16-22 at 8:36am. The Rehabilitation Director stated Resident #74 had been on services from 2-15-22 to 3-30-22 and had been ordered to have elbow splints placed on each elbow one at a time for up to 4 hours.

Nurse #5 was interviewed on 6-16-22 at 8:45am. Nurse #5 confirmed she was familiar with Resident #74 and stated she was not aware the resident had been ordered elbow splints. She also stated she had not seen Resident #74 wearing elbow splints over the last month she had been assigned to him.

An interview with Nursing Assistant (NA) #12 occurred on 6-16-22 at 8:52am. NA #12 stated she was familiar with Resident #74 and remembered the resident having elbow splints "several months ago." She said since then she had not seen Resident #74 with elbow splints. NA #12 stated if he had elbow splints ordered and it was on the NA care guide, she would have placed the elbow splint on Resident #74.

The Regional Corporate Nurse was interviewed on 6-16-22 at 2:00pm. The Regional Corporate Nurse stated Resident #74's family member had been placing the elbow splints on the resident.

Resident #74's family member was interviewed on 6-16-22 at 2:15pm. The Family member stated she had been putting on the elbow splints for Resident #74 but had stopped in March 2022. She stated, "I stopped because the staff said I was putting them on wrong."

Provider's plan of correction: necessary. Will be monitored by the Administrator

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Observation of Resident #74 occurred on 6-16-22 at 2:15pm. Resident #74 was observed not to have his elbow splint applied.
The facility physician was interviewed by telephone on 6-16-22 at 2:30pm. The physician stated staff should be following therapy recommendations and physician orders.

Resident #74 was observed on 6-17-22 at 12:40pm. The Resident was observed to be in the bed and did not have his elbow splint applied.

The Administrator was interviewed on 6-17-22 at 4:58pm. The Administrator stated staff should be following physician orders and meeting the needs of the residents.
2. Resident #46 was admitted to the facility on 09/15/2020 with a diagnosis of hemiplegia (loss of muscle function on one side of the body) after cerebral infarction (disrupted blood flow to the brain).

A review of the quarterly Minimum Data Set (MDS) assessment for Resident #46 dated 04/15/2022 revealed she was cognitively intact. She had functional limitation in range of motion of the upper and lower extremities on one side of her body. She did not receive any Occupational Therapy (OT) or any restorative nursing program splint or brace assistance in the 7 day look back period of the assessment.

A physician's order for Resident #46 dated 01/28/2022 revealed she was to wear her left hand splint from 9AM-9PM.

On 06/15/2022 at 9:53 AM an observation of Resident #46 revealed she did not have her left

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hand splint on.

On 06/15/2022 at 3:05 PM an observation of Resident #46 revealed she did not have her left hand splint on. An interview with Resident #46 at that time indicated her left hand splint had not been put on that day. She stated she was not able to apply the splint herself. She went on to say no one offered to put her left hand splint on that day. She stated she had not asked anyone to put it on. She further indicated she did not feel she should have to ask staff to put her hand splint on every day, they should know.

On 06/16/2022 at 10:45 AM an observation of Resident #46 revealed she did not have her left hand splint on. In an interview at that time, Resident #46 stated her left hand splint had not been put on that day.

A review of the Treatment Administration Record (TAR) dated June 2022 for Resident #46 revealed documentation by Medication Technician (MT) #1 that Resident #46 had her left hand splint on at 9:00 AM on 06/15/2022 and 06/16/2022.

On 06/16/2022 at 11:05 AM an interview with MT #1 indicated Resident #46 had a physician's order for her left hand splint to be worn daily from 9AM-9PM. She went on to say this popped up on the TAR for her to do. She further indicated she documented Resident #46 had her left hand splint on 06/15/2022 at 9:00 AM because she placed it on Resident #46. MT #1 stated either Resident #46 or the Nurse Aide (NA) assigned to Resident #46 that day must have taken it off after she put it on. She went on to say she documented Resident #46 had her left hand splint on 06/16/2022 at 9:00 AM but she had not actually put it on her. She

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stated Resident #46 was still in the shower at 9:00 AM and she had not gone back to put the splint on later.

On 06/16/2022 at 5:48 PM a telephone interview with Nursing Assistant (NA) #2 indicated she cared for Resident #46 on 06/15/2022 on the 7AM-3PM shift. She stated she had not observed Resident #46 to have her left hand splint on that day. She stated she had not removed it.

On 06/16/2022 at 11:11 AM an interview with the Director of Nursing (DON) indicated Resident #46 had a physician's order for her left hand splint to be placed daily from 9AM-9PM on the TAR. She stated this should have been on as per the physician's order.

On 06/16/2022 at 1:45 PM a telephone interview with Occupational Therapist (OT) #1 indicated Resident #1 had muscle tightness in her left hand. She stated Resident #46 had been instructed in range of motion exercises for her left hand that she could perform herself. She went on to say the left hand splint was recommended for Resident #46 to prevent a contracture (a permanent tightening of the muscles and other structures that causes joints to shorten and become stiff). OT #1 stated the recommendation had been passed along to nursing staff who took care of getting the physician's order. She went on to say while the risk of developing a contracture to her left hand was low because Resident #46 was able to perform her range of motion exercises independently, she should have her left hand splint applied daily.

On 06/16/2022 at 2:45 PM a telephone interview with Physician (MD) #1 indicated if he gave an

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F 688	Continued From page 61 order for Resident #46's left hand splint to be on from 9AM-9PM daily he expected this to be followed. On 06/17/2022 at 2:40 PM an interview with the Administrator indicated if Resident #46 had a physician's order for a left hand splint to be on from 9AM-9PM this should have been followed.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and physician interviews the facility failed to provide 1:1 supervision of a resident as ordered by the physician. This was for 1 of 8 residents reviewed for supervision to prevent accidents. (Resident #83) Findings included: Resident #83 was admitted to the facility on 08/03/2017 with a diagnosis of cerebral infarction (disrupted blood flow to the brain). A review of the quarterly Minimum Data Set (MDS) assessment for Resident #83 dated 05/20/2022 revealed he was severely cognitively impaired. He required the limited assistance of	F 689	The facility failed to provide 1:1 supervision of a resident as ordered by the physician. This was for 1 of 8 residents reviewed for supervision to prevent accidents. Resident #83 documentation was reviewed for behaviors, and none noted 1:1 order discontinued on 06/20/2022. Scheduler educated on assigning sufficient staff to 1:1 resident on 06/20/2022. Nurse #2, nursing staff, and agency was educated on informing director of nursing when 1:1 staff not available or leaves on 06/20/2022 through 07/15/2022.	7/15/22

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one person for transfers and mobility. He used a wheelchair (WC). Resident #83 had no behaviors, rejection of care or wandering during the 7 day look back period of the assessment.

A review of a nursing progress note for Resident #83 dated 06/10/2022 at 4:25 PM revealed the Director of Nursing (DON) obtained a physician's order to discontinue Resident #83's 1:1 supervision from 7:00 PM to 7:00 AM as Resident #83 had demonstrated no inappropriate behaviors. The note further revealed the physician ordered the 1:1 supervision continued from 7:00 AM to 7:00 PM daily.

On 06/16/2022 at 3:07 PM a telephone interview with Nurse #3 indicated she was assigned to care for Resident #83 on 06/13/2022 from 3:00 PM to 7:00 PM. She stated she knew Resident #83 was supposed to have 1:1 supervision due to an episode where he inappropriately entered another resident's room but there had been no one assigned from 3:00 PM to 7:00 PM that day. She went on to say she had not notified anyone and she was not given an explanation why this coverage was not in place. Nurse #3 stated she just did her best to try to keep an eye on him during that period. She went on to say she had not observed Resident #83 going into any other residents' rooms.

On 06/14/2022 at 6:08 PM an interview with Nurse #2 indicated Resident #83 did not have 1:1 supervision from 3:00 PM to 7:00 PM. She stated she was the nurse for Resident #83. She stated there was 1 nurse and 1 nursing assistant (NA) to care for the residents on the hall where Resident #83 resided. She went on to say she was aware Resident #83 was supposed to have 1:1

F 689

All residents that have orders for 1:1 have the potential to be affected. Orders reviewed by MDS and Director of nursing for the past 30 days. If any issues noted the medical director will be informed. There were no further 1:1 order

Staff will be educated by Director of Nursing and/or designee starting 06/20/2022 through 07/15/2022 and on newly hire on informing Director of Nursing on when 1:1 staff not available or leaves.

Director of Nursing will over see the scheduler to ensure that any residents that's placed on 1:1 has staff per MD orders. Any staff found to be out of compliances will be reeducated and corrective actions taken.

Observations of NAs/staff assigned to 1:1 will occur 5 x week x 1week, 3 times per week x1 and 1 time per week x 4 weeks and continue until the QAPI Committee determines the deficient practice is resolved. Observation will be performed by the DON, ADON, UM and or any other licensed nurse.

Results of the observation will be presented to the QAPI committee by the DON, ADON, and/or UM x 2 months or until resolution. Will be overseen by Administrator

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F 689	Continued From page 63 supervision for safety from 7:00 AM to 7:00 PM because he had an episode of going into another resident's room. Nurse #2 stated there had not been anyone assigned 1:1 with Resident #83 from 3:00 PM to 7:00 PM on 06/14/2022. She went on to say the NA who was 1:1 with Resident #83 from 7:00 AM to 3:00 PM reported to her she when she was leaving. She stated she did her best to try to keep an eye on Resident #83 to make sure he didn't go into any other residents' rooms. She further indicated it was possible both she and the NA would be needed in another room and there would be no one supervising Resident #83. She stated she asked the Staffing Coordinator about coverage for this shift but had been told there wasn't any. Nurse #2 stated Resident #83 was able to transfer into his WC by himself. She further indicated once he was in his WC, he could independently propel it in the halls. She stated she had not observed Resident #83 go into any other residents' rooms. On 06/14/2022 at 6:23 PM an interview with NA #4 indicated he was the NA assigned to the hall where Resident #83 resided on 06/13/2022 and 06/14/2022 from 3:00 PM to 7:00 PM. He stated there was 1 nurse and 1 NA for these residents. He stated he was aware that Resident #83 was supposed to have 1:1 supervision from 7:00 AM to 7:00 PM but on 06/13/2022 and 06/14/2022 there had been no one assigned to be 1:1 with Resident #83 from 3:00 PM to 7:00 PM. He stated he did his best to keep an eye on Resident #83 to be sure he didn't go into any other residents' rooms but it was possible both he and Nurse #2 would be in another room and no one would be supervising Resident #83. NA #4 went on to say he had never observed Resident #83 going into any other residents' rooms.	F 689		

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On 06/14/2022 at 6:28 PM an observation of Resident #83 revealed he was self-propelling his WC in the hallway. He was not observed to enter any other residents' rooms. Nurse #2 was observed to be present on the hall.

On 06/14/2022 at 6:31 PM the Administrator was observed to ask Resident #83 if he wanted to go get some cake. Resident #83 agreed and the Administrator was observed to take Resident #83 with her.

On 06/15/2022 at 10:23 AM an interview with the DON indicated Resident #83 had been on 1:1 supervision 24 hours daily due to an episode where he inappropriately entered another residents room and was observed to be touching the resident. She stated while there was no evidence this had been abuse, the team communicated with Resident #83's physician and 1:1 supervision was determined to be the most effective intervention at the time. She further indicated Resident #83 had been doing well with the 1:1 supervision, did not mind it and had not demonstrated any wandering or sexual behaviors. The DON stated she spoke with Resident #83's physician on 06/10/2022 and obtained a verbal order to decrease the 1:1 supervision to 7:00 AM to 7:00 PM daily. She further indicated she had written this as a verbal order and it was currently in the physician's logbook awaiting his signature. She stated the physician came in weekly to sign these verbal orders and had not been in yet that week. She went on to say Resident #83 should have had 1:1 supervision during these hours as ordered by his physician. She further indicated she felt the problem was a lack of communication about

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F 689	Continued From page 65 assignments. On 06/16/2022 at 3:58 PM an interview with NA #5 indicated she was the Staffing Coordinator. She stated Resident #83 was supposed to have 1:1 supervision from 7:00 AM to 7:00 PM daily for safety. She went on to say this was due to an episode where Resident #83 inappropriately entered another resident's room. NA #5 stated she normally had no trouble getting staff for 1:1 supervision with Resident #83. She went on to say no one let her know that there was no staff member to cover the 1:1 shift with Resident #83 on 06/13/2022 from 3:00 PM to 7:00 PM. She stated if someone had let her know, she could have covered this herself. NA #5 further indicated on 06/14/2022 from 3:00 PM to 7:00 PM NA #6 was supposed to be 1:1 with Resident #83 from 3:00 PM to 7:00 PM. She stated no one notified her at 3:00 PM when the NA from the 7:00 AM to 3:00 PM shift left without anyone replacing her. She went on to say when she was notified later that evening no one was 1:1 with Resident #83 the Administrator came to get him. On 06/15/2022 at 2:30 PM an interview with NA #6 indicated no one told her she was scheduled to be 1:1 with Resident #83 on 06/14/2022 from 3:00 PM to 7:00 PM. She stated the staff schedules were posted at the nurses stations and at the time clocks. She stated she worked 7:00AM to 3:00 PM on 06/14/2022 on another unit. She stated she checked her schedule that morning when she got to work and there was nothing to indicate she was supposed to be 1:1 with Resident #83 from 3:00 PM to 7:00 PM that day. NA #6 stated she took her job seriously and if someone had let her know she was supposed to cover that assignment she would not have	F 689		

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F 689	Continued From page 66 gone home at 3:00 PM. She stated she felt it was poor communication. On 06/16/2022 at 2:45 PM a telephone interview with Physician (MD) #1 indicated Resident #83 was placed on 1:1 supervision after an episode where he was observed touching another resident. He stated there had been no evidence there was anything sexual or abusive about the contact. He stated a psychiatric consult was initiated. He went on to say 1:1 supervision was not a long term solution. MD #1 went on to say he had given the DON a verbal order to decrease the 1:1 supervision to 7:00 AM to 7:00 PM because Resident #83 had not demonstrated any further behaviors after the incident. He stated the goal was to not have Resident #83 on 1:1 supervision at all. He went on to say he would have expected Resident #83 to have 1:1 supervision from 7:00 AM to 7:00 PM as he ordered. On 06/17/2022 at 2:40 PM an interview with the Administrator indicated while staff were keeping an eye on Resident #83 on 06/13/2022 and 06/14/2022 from 3:00 PM to 7:00 PM, this was not 1:1 supervision. She stated Resident #83 should have had 1:1 supervision during these times as ordered by his physician.	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	F 690		7/15/22

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F 690	Continued From page 67 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; (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 observations record review, staff and family interviews, Nurse Practitioner and Physician interviews, the facility failed to collect a urine sample from Resident #59 per physician order and failed obtain a stat urinalysis for Resident #346 because the lab was not notified to pick up the sample and process for 2 of 2 residents reviewed for urinary tract infections (Resident #59 and Resident #346).	F 690	Resident # 59 completed antibiotics for her UTI on 2/21/2022. Resident # 346 is no longer in the facility. An audit for lab compliance was performed for the last 30 days. No discrepancies were found for the last 30 days.	

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Findings Include:

1. Resident #59 was admitted to the facility on 6/13/20 with diagnoses including depression and cognitive communication deficit.

The quarterly Minimum Data Set (MDS) dated 12/16/21 revealed Resident #59 had severe cognitive impairment. She required extensive assistance with bed mobility and transfers. She required total assistance with toileting. Resident #59 had no urinary tract infections (UTI) in the past 30 days.

Record review revealed a physician order dated 1/27/22 for straight catherization x 1 now for urine analysis and culture and sensitivity to rule out UTI. This order was transcribed by Nurse #6 on 1/27/22 at 3:14 PM.

On 6/16/22 at 9:00 AM an interview was conducted with Nurse #6, and she stated she did not collect the urine on 1/27/22 for Resident #59. She stated Resident #59 was out of bed in her wheelchair and she asked the oncoming night nurse (Nurse #7) if she would do it and Nurse #7 said she would collect the urine. Nurse #6 stated she remembered the former Assistant Director of Nursing (Nurse #1) calling her a couple of days later and asking her if she collected the urine.

An interview was conducted with Nurse #7 on 6/17/22 2:10 PM and she remembered collecting the urine and placing it in the refrigerator. She stated the urine sample got lost and someone else had to collect the lab, but she did not know who did the collection.

A unit manager has been designated to be responsible for lab compliance as of 7/6/2022.

The unit manager was educated on 7/6/2022 by the Regional Nurse on the lab process and the use of the lab audit tool. The unit manager will audit lab orders daily via the audit tool Monday-Friday for completion.

All licensed nurses will be educated on the lab process by 7-15-2022.

All audit results will be discussed in monthly QAPI meeting x 3 months or until substantial compliance is achieved. Administrator will oversee

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An interview was conducted with the Nurse Practitioner (NP) on 6/17/22 at 2:00 PM, and she stated when a urine order is placed, she preferred the collection within 24 hours and a phone call to the NP or the Physician if there were issues with retrieving the urine. During the interview, the NP was observed looking at the progress notes in Resident #59 ' s chart. She stated she did not know why it took 4 days for Resident 59 ' s urine to be collected because there where no progress notes in the chart regarding the urine collection. The NP stated Resident #59 could have become septic and hospitalized.

An interview was conducted with Nurse #1 at 6/17/22 at 3:04PM with Nurse #1 and she stated she remembered the incident but could not remember any details about it.

The lab results indicated Resident #59 ' s urine was collected on 1/31/22 at 1:45 PM. The urine received date by the lab was 2/1/22 and results reported date was 2/3/22.

An order was placed by the Physician on 2/2/22 for an antibiotic to treat Resident #59 ' s UTI.

An interview with the Director of Nursing was conducted on 6/17/22 at 4:53 PM and she stated urine should be collected within 24 hours and waiting 3-4 days to collect urine was unacceptable.

2. Resident #346 was admitted on 04/25/2022 with diagnoses which included dementia, urinary tract infection (UTI), and presence of cardiac pacemaker.

A review of Resident #346's admission Minimum

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F 690	Continued From page 70 Data Set (MDS) dated 04/25/2022 revealed she was cognitively intact and required extensive assistance with all Activities of Daily Living (ADLs). A review of Resident #346's medical record revealed an order was written on 04/18/2022 at 1:11 pm by Physician #1 to obtain a STAT urine for urinalysis and culture and sensitivity to rule out UTI. A review of Nurse #13's progress note dated 04/18/2022 at 4:01 PM revealed the "urine was collected by catherization as per order to rule out UTI". A review of the lab reports for Resident #346 revealed no results for the STAT urinalysis collected on 04/18/2022. A review of the "Lab" book housed at the nurse's stations revealed the logged dates of 05/30/2022 - 06/12/2022 for laboratory collections for the facility. Review of the logged lab forms for the date of 04/18/2022 was not able to be located by the facility for review. Interview with Nurse #13 on 06/16/2022 at 2:07 pm revealed she remembered that the lab never picked up the urine for processing. Nurse #13 stated she didn't realize the urine hadn't been picked up by the lab until several days later. An interview with a family member of Resident #346 on 06/13/2022 at 3:44 pm revealed she visited Resident #346 on 04/20/2022 and Resident #346 was confused and disoriented. The family member spoke to Nurse #12 about these concerns and requested Resident #346 be	F 690		

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sent to the local hospital for evaluation.

Review of Nurse #12's progress note dated 04/21/2022 at 12:10 am read in part, "Sent resident at approximately 9:00 pm on 4/20/22 to the emergency room (ER) for evaluation related to UTI. Family requested resident to be sent to ER; vital signs were stable and zero pain level."

A review of the hospital discharge summary dated 04/22/2022 revealed Resident #346 was diagnosed with a UTI, started on an antibiotic, and was sent back to the facility.

An additional interview with Nurse #13 on 06/16/2022 at 1:38 pm revealed she was unaware that when she received the STAT urine collection order for Resident #346 that the order had to be entered into a separate electronic medical system specifically for the lab that notified them of the STAT order. Nurse #13 also stated there is a book at each nurse ' s station labeled "Lab" so each lab order could be written and documented as a communication tool for the lab to look at each day that notifies them of what labs needed to be done and collected. Nurse #13 stated she couldn ' t remember if she wrote the STAT urine in the "Lab" book or not on 04/18/2022.

An interview with the Director of Nursing on 06/16/2022 at 2:10 pm revealed the facility ' s process for communication with the lab were as follows:
Enter new order into the lab system's electronic program.
Call the lab with all STAT orders.
Write the lab in the book labeled "Lab" at the nurse's station.

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F 690	Continued From page 72 Each day, check to see the status of the labs by checking the logbook and the refrigerator for any uncollected labs. The Director of Nursing stated the facility had been experiencing communication breakdown with the lab and had been trying to reach the lab to discuss a plan of resolution, however, the DON stated she had not been successful in reaching someone at the lab after several attempts. The DON stated that Nurse #13 failed to enter Resident #346's STAT order in the lab's electronic medical system, failed to call the lab to alert them of the STAT order and failed to write Resident #346's urine collection in the "lab" book and due to these reasons, the lab didn't know to pick up the collected urine. An interview with the Administrator on 06/16/2022 at 3:46 pm revealed Nurse #13 failed to follow the complete facility process for lab collection for Resident #346. An interview with Physician #1 on 06/16/2022 at 2:15 pm revealed he was notified by nursing or administration that the lab did not pick up the collected urine for Resident #346 during resident rounds on 04/22/2022. He stated at that time, he re-ordered the culture and urinalysis treated accordingly to cover Resident #346's UTI. Physician #1 also stated he expected to be notified within 24 hours if a STAT lab was not picked up by the lab for testing.	F 690		
F 725 SS=G	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with	F 725		7/15/22

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F 725	Continued From page 73 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 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, observation, resident and staff interviews the facility failed to provide sufficient staffing to assist with Activities of Daily Living (ADL) care for residents (Resident #20 and Resident #8) who were dependent on facility staff for ADL care. Resident #20 voiced feeling "awful" and that staff did not care about her. Resident #8's scrotum and buttocks were bright red and voiced he had pain when they were cleaned. The NA was observed to apply protective barrier cream to Resident #8's scrotum and buttocks. This affected 2 of 5 residents reviewed for	F 725	On 6/16/22 the Director of Nursing/designee ensured resident #20 and #8 received ADL care. Current dependent resident□s dependent on ADL care is at risk. The Director of Nursing and the scheduler reviewed the staffing schedule for the next week to ensure there was adequate staffing to meet the needs of the residents throughout all shifts.	

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F 725	Continued From page 74 staffing. Findings included: This citation is cross-referenced to: F677 Based on record review, observation, resident and staff interviews the facility failed to provide incontinence care and showers for 2 of 2 dependent residents (Resident #20 and Resident #8) reviewed for Activities of Daily Living (ADL) care. Resident #20 voiced feeling "awful" and that staff did not care about her. Resident #8's scrotum and buttocks were bright red and Resident #8 voiced pain when his scrotum and buttocks was cleaned. The Nursing Assistant (NA) #9 applied protective barrier cream to Resident #8's scrotum and buttocks. Review of the facility's daily staffing schedule for June 2022 revealed the following: -6/9/22 there were 3 Nursing Assistants (NA) for approximately 36 residents on the 7:00am to 7:00pm shift for station 2. -6/11/22 there were 3 Nursing Assistants (NA) for approximately 36 residents on the 7:00am to 7:00pm shift for station 2. -6/12/22 there were 2 Nursing Assistants (NA) for approximately 36 residents on the 7:00am to 7:00pm shift for station 2. -6/13/22 there were 3 Nursing Assistants (NA) for approximately 36 residents on the 7:00am to 7:00pm shift for station 2.	F 725	On 7/11/22 the Administrator educated the Director of Nursing, Assistant Director of Nursing and Scheduler on the requirements of acuity-based staffing needs. The Director of nursing was educated on the use of the company electronic (Prime View) program to determine acuity-based needs. On 7/11/22 the Administrator, Director of Nursing and scheduler implemented daily labor meetings to ensure there was adequate staff to meet the needs of the residents by reviewing the current/upcoming schedule and utilizing the company electronic program (Prime View) which provides acuity-based staffing levels needed. The labor meeting will include the schedule review, supplemental staffing needs and recruiting efforts. Staffing needs will be addressed by the Director of Nursing, Assistant Director of Nursing/designee and scheduler. Current staff will be requested to work for additional pay and/or supplemental contract staff will cover the needs. Acuity based staffing needs will be reviewed 5X a week for two weeks, biweekly for 2 weeks and weekly for 8 weeks. Staffing level needs/changes will be addressed when/if noted. The Director of Nursing will bring the results of all audits to the monthly Quality Assurance Performance Improvement	

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F 725	Continued From page 75 During an interview with the facility's scheduler on 6-17-22 at 11:48am, the scheduler stated she began her position in March 2022 and was educated by the Director of Nursing and Administrator to schedule per census. She explained she was not taught to take acuity, resident care plans or resident needs into account when she was developing the schedule. The scheduler discussed trying to keep 4 NAs on station 2 during the 7:00am to 7:00pm shift but said most of the time there were only 3 NAs. She discussed the facility using agency staff to try and cover shifts and when there were call offs, she first attempted to have the facility staff cover and then she would contact the agency. The Administrator was interviewed on 6-17-22 at 4:58pm. The Administrator stated she was unaware the scheduler was scheduling by census. She explained the schedule should reflect the number of staff needed by the acuity of the residents.	F 725	(QAPI) meeting for review by the QAPI Committee for patterns/trends for 3 months. The Committee will address negative findings if noted. Additional interventions will be developed by the Committee and implemented by the Administrator and Social Worker as needed to sustain substantial compliance.	
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	F 727		7/15/22

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F 727	Continued From page 76 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 23 of 26 days (4-1-22, 4-2-22, 4-3-22, 4-4-22, 4-6-22, 4-11-22, 4-12-22, 4-15-22, 4-23-22, 4-24-22, 4-25-22, 4-26-22, 5-3-22, 5-7-22, 5-9-22, 5-14-22, 5-15-22, 5-17-22, 5-18-22, 5-23-22, 5-27-22, 6-3-22, and 6-12-22) reviewed for staffing. Findings included: Review of the daily staffing sheets from 4-1-22 through 6-16-22 revealed there was no RN scheduled for the following days; 4-1-22, 4-2-22, 4-3-22, 4-4-22, 4-6-22, 4-11-22, 4-12-22, 4-15-22, 4-23-22, 4-24-22, 4-25-22, 4-26-22, 5-3-22, 5-7-22, 5-9-22, 5-14-22, 5-15-22, 5-17-22, 5-18-22, 5-23-22, 5-27-22, 6-3-22, and 6-12-22. During an interview with the facility scheduler on 6-17-22 at 11:48am, the scheduler explained she began helping with the schedule in February 2022 and took over the position in March 2022. The scheduler reviewed the days there was not an RN present on the daily staffing sheet and responded there was not an RN on duty because the facility could not find an RN through the agency to work, and the facility did not have an RN at the time. She explained the facility has hired an RN to work at least the 8 consecutive hours a day. The Administrator was interviewed on 6-17-22 at 4:58pm. The Administrator acknowledged the days the facility did not have an RN scheduled,	F 727	No resident identified. On 6/20/22 The Administrator reviewed the current schedule to ensure we had RN coverage daily thru 7/11/22. As of 6/20/22 the Administrator/Director of Nursing have hired 3 RNs. On 7/1/22 the Administrator educated the Director of Nursing and scheduler regarding the regulatory requirement of 8 hours of RN coverage daily. On 7/1/22 the Director of Nursing educated the Staff Development Coordinator and Unit Managers referencing the requirement of RN coverage 8 hours daily. RN callouts will be reported to the Administrator/Director of Nursing when received. The Assistant Director of Nursing, Staff Development Coordinator, Unit Managers and/or other staff RN will be notified of the call-out and one will be assigned to work the 8 hours. The Director of Nursing will bring the results of the RN coverage to the Quality Assurance and Performance (QAPI) meeting monthly for 3 months for review by the QAPI committee. Negative findings will be addressed when/if noted. This plan of correction constitutes a written allegation of compliance.	

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F 727	Continued From page 77 but stated the facility has hired 2 RN's.	F 727	Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged, or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of the requirement under state and federal law and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident.	
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 observation and staff interviews the facility failed to discard expired food items stored ready for use in the reach-in and walk-in	F 812	On 6/13/22 the Dietary Manager (DM) discarded all unlabeled, outdated and aged produce. Items placed on the floor	7/15/22

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F 812	Continued From page 78 refrigerator and failed to ensure that food items in the walk-in freezer and dry storage area were not stored on the floor. The facility also failed to allow dishware to air dry before being nested for storage. This practice has the potential for cross contamination of food served to residents. This was evident in 2 of 2 kitchen observations. Findings included: An observation of the facility kitchen on 6/13/2022 at 10:35AM revealed the following: 1. a. The reach-in refrigerator had an opened half full plastic storage container of coleslaw that was labeled and dated 6/10/2022. b. The reach-in refrigerator had 1 opened half full plastic storage container of potato salad that was labeled and dated 6/10/2022. c. The reach-in refrigerator had a ¼ full metal steam table pan of sloppy joe sauce that was labeled and dated 6/9/2022. d. The reach-in refrigerator had a 3/4 full metal steam table pan of cheddar cheese sauce that was labeled and dated 6/4/2022. e. The reach-in refrigerator had a ¼ full metal steam table pan of beef stew that was labeled and dated 6/10/2022. 2.a. The walk-in refrigerator had 1 divided plate with 3 sections filled with pureed food that was labeled and dated 6/11/2022. b. The walk-in refrigerator had a metal steam table pan of shredded lettuce that was dated 6/6/2022. The lettuce was observed to be yellow with dark brown edges and the inside of the metal pan contained brown liquid. 3.a. The walk-in freezer had a large, unopened box of frozen 4-inch pancakes stored on the floor. 4.a. The dry storage area had 1 case of mashed potato granules and 1 case of 12-ounce foam cups that were stored on the floor.	F 812	were removed and stored properly on the shelves in the walk-in freezer and walk in refrigerator. The DM also removed the items noted on the floor in the dry storage area and stored the item properly. The DM and dietary aide rewashed the coffee mugs and clear plastic cups and placed upside down on metal shelves to air dry preventing wet nesting and the discolored mugs were discarded. On 6/13/22 the Dietary Manager was educated by the Regional Director of Operations on the policy for and procedure discarding food items when out of date or not labeled, proper food storage in the walk-in refrigerator and freezer, the labeling/dating and storage of dry goods and the proper procedure for the drying of dishware and preventing of wet nesting. The Dietary Manager conducted education on proper food storage, dating/labeling of food products, the timeline of when items need to be discarded and when there is aged produce it is to be discarded on 6/13/22. On 6/15/22 the Dietary Manager educated the staff on proper storage of dishware and the airdrying process to prevent wet nesting and to discard dishware that was in poor condition/severely stained. Current dietary staff will be educated prior to working the next scheduled shift and on hire.	

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F 812

Continued From page 79

An interview with the dietary manager on 6/13/2022 at 10:48PM revealed these identified food items in the reach-in refrigerator should be used or pulled from the refrigerator by 6/12/2022. He stated the food items identified should have been tossed on 6/11/2022. The dietary manager stated that the facility policy is the food should be used by the date on the food plus two days. The dietary manager also reported the items should not be left on the floor and should be stored on the shelves in the area.

5. Observation of the dish machine operation was completed 6/15/2022 at 10:20AM. On open, metal shelves near the dish machine, there were plastic, beige colored coffee mugs that were turned upside down. Eighteen of the coffee mugs were observed to be stored wet and were turned upside down on a flat tray that did not allow air to circulate. There were also 4 beige colored plastic mugs that were heavily stained inside with dark brown matter. Also observed on the open metal shelves were 24 12-ounce clear plastic cups that were stacked inside each other. The insides of the clear cups were wet. The clear, 12-ounce cups were stacked upright on open metal shelves.

An interview with the dietary manager on 6/15/2022 at 10:33AM revealed the mugs and cups should be allowed to air dry and should not be stacked wet. The dietary manager stated the stained mugs needed to be soaked and de-stained. He also reported the mugs and cups that were wet were to be used for the upcoming meal and would need to be washed again and allowed to air-dry.

F 812

Systemic measures implemented to prevent the recurring of the deficient practice:
New racks were purchased by the facility on 6/14/22 to ensure appropriate drying and prevention of wet nesting of dishware.

The Administrator, Dietary Manager or designee will conduct audits to ensure the labeling/dating of food products in the refrigerators, walk-in freezer and dry storage area are labeled/dated, stored properly, dishware is being air dried and not wet nested or in poor condition/stained daily for 2 weeks and then biweekly for 10 weeks. The results of the audits will be reviewed daily, Monday thru Friday, during the IDT meeting for 2 weeks. Negative findings will be corrected when/if noted.

The results of all audits will be taken to the facility Quality Assurance and Performance Improvement (QAPI) meeting by the Dietary Manager for 3 months. The QAPI Committee will review the audits and additional interventions will be developed by the Committee and implemented by the Dietary Manager to ensure sustained compliance.

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F 812	Continued From page 80 An interview with the administrator was conducted on 6/15/2022 at 1:25PM revealed that all items in the kitchen should be stored and disposed of according to regulations.	F 812		
F 814 SS=F	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the area surrounding the dumpster free from trash and debris. This was evident in 2 of 2 observations of the dumpster area. The findings included: An observation of the dumpster area on 6/13/2022 at 2:30PM revealed there were numerous pieces of cardboard, 8 blue latex gloves, 3 plastic drink straws, 1 battery, 1 plastic automotive oil container, and 4 wheelchairs on the concrete pad. Another observation of the dumpster area was conducted 6/15/2022 at 10:35AM. The observation revealed there were numerous pieces of cardboard, 12 blue latex gloves, 1 battery, 1 plastic automotive oil container, and 4 wheelchairs. There were also 2 small plastic bags, 1 soft drink can and 3 face masks. Interview with the dietary manager on 6/15/2022 at 10:35AM revealed although every department in the facility contributed to the trash that was accumulated in the dumpsters, he was not certain who had the ultimate responsibility for keeping the dumpster area clean. He reported he thought	F 814	The facility failed to maintain the area surrounding the dumpster free from trash and debris. This was evident in 2 of 2 observations of the dumpster area. Dumpster area cleaned and new dumpsters delivered to facility and old dumpsters removed on 06/16/2022. Dietary Manger was educated by the Reginal director of operations on responsibility of the dumpster area on 06/15/2022. Dietary Manger educated staff on the responsibility of the cleaning of the dumpster area on 06/15/2022 Housekeeping Manger and Maintenance Director was educated on keeping the dumpster area clean and picking up trash when dropped 06/16/2022. The dumpster area was cleaned on 06/16/2022. New dumpsters were delivered to the facility on 06/16/2022	7/15/22

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F 814	Continued From page 81 all departments worked together to keep the area clean. Interview with the facility administrator on 6/16/2022 at 8:33AM revealed that all departments work together to keep the dumpster area clean.	F 814	Random checks will be completed by Dietary Manger 5x weekly x 2 weeks, 3x weekly times 2 weeks, weekly x1 week and weekly for 2 months then randomly x monthly. Results we be evaluated during IDT meeting the next day and if done Friday, Saturday, and Sunday the IDT will review on Monday. Data collected during the audit will be analyzed for patterns, and trends and reported to QAPI by the Dietary Manger monthly x 3 months. The QAPI committee will evaluate the effectiveness of the intervention to determine if to continue the auditing process is necessary to maintain compliance. The Administrator will oversee the process.	
F 838 SS=F	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's	F 838		7/15/22

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F 838 Continued From page 82 F 838

resident capacity;
(ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population;
(iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population;
(iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and
(v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.

§483.70(e)(2) The facility's resources, including but not limited to,
(i) All buildings and/or other physical structures and vehicles;
(ii) Equipment (medical and non- medical);
(iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies;
(iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care;
(v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and
(vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.

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F 838	Continued From page 83 §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to review and annually update the Facility Assessment. Findings included: Review of the Facility Assessment revealed a cover page dated 2-21-21. The documents following the cover page were observed to be dated February 2019. Further investigation of the Facility Assessment information revealed the information regarding the resident level of independence to dependence was derived from the 2019 annual survey and the resident population for special treatments and conditions was derived from the clinical systems review dated 1-1-2018 through 12-31-2018. The Administrator was interviewed on 6-17-22 at 4:58pm. The Administrator stated she understood the Facility Assessment was out of date and that she needed to update the Facility Assessment.	F 838	No Resident identified Current facility residents have the potential to be affected by the same deficient practice. No Resident identified Regional Director of Plant Operations educated the Maintenance Director and Administrator on the process for updating the Facility Assessment annually on 07/01/2022. Any resident has the potential to be affected by the alleged deficient practice. Facility Administrator and Maintenance reviewed the current facility assessment on 07/01/2022, and updated on risk assessment, facility resources, resident population, special treatments and facility staff. The Annual Facility Assessment data will be released by the Corporate Compliance Committee during the month of August. The Administrator, Maintenance Director and Director of Nursing will analyze the data to ensure accuracy. This data will be utilized to compile the Annual Facility Assessment which is due in September. The Corporate Compliance Office will send email reminders of the due date. The Regional Director of Operations will validate the Facility Assessment has been	

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F 838	Continued From page 84	F 838	updated and sent to Corporate Compliance by the date it is due. The Maintenance Director and/or Administrator will bring the Annual Facility Assessment to the Quality Assurance Performance Improvement meeting to be reviewed by the QAPI Committee quarterly. The Facility Assessment will be reviewed/updated annually and/or quarterly as needed when changes occur.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-	F 842		7/15/22

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F 842	Continued From page 85 (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic	F 842		

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F 842 Continued From page 86

services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on observations, record review and resident and staff interviews the facility failed to accurately document the placement of a left hand splint for 1 of 2 residents reviewed for positioning and mobility. (Resident #46)

Findings included:

Resident #46 was admitted to the facility on 09/15/2020 with a diagnosis of hemiplegia (loss of muscle function on one side of the body) after cerebral infarction (disrupted blood flow to the brain).

A review of the quarterly Minimum Data Set (MDS) assessment for Resident #46 dated 04/15/2022 revealed she was cognitively intact. She had functional limitation in range of motion of the upper and lower extremities on one side of her body. She did not receive any Occupational Therapy (OT) or any restorative nursing program splint or brace assistance in the 7 day look back period of the assessment.

A physician's order for Resident #46 dated 01/28/2022 revealed she was to wear her left hand splint from 9AM-9PM.

On 06/15/2022 at 9:53 AM an observation of Resident #46 revealed she did not have her left hand splint on.

On 06/15/2022 at 3:05 PM an observation of Resident #46 revealed she did not have her left hand splint on. An interview with Resident #46 at that time indicated her left hand splint had not

F 842

Resident #46 was reassessed by Occupational Therapy for the need of hand splint on 7/7/22. It was determined the hand splint orders were appropriate.

Current residents were screened by Occupational Therapy on 7/11/22 for contracture management. Residents with new or increased contractures and those with current splints will be addressed by therapy to ensure appropriate treatment is initiated by 7/15/22.

Beginning 7/11/22 the Occupational Therapist will educate the Restorative Aide on proper application of current splints.

Beginning 7/12/22 residents with splints will have the splint applied by the Restorative Aide/designee. The Restorative Aide/designee will document the application.

The charge nurse will validate the splint application and document on the resident's medication administration record.

The Director of Nursing/designee will conduct audits on 5 residents with splints 5 days a week for 4 weeks and biweekly times 4 weeks and weekly times 4 to ensure splint application and documentation has been completed by the Restorative Aide/Charge Nurse.

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F 842	Continued From page 87 been put on that day. She stated she was not able to apply her splint herself. She went on to say no one offered to put her left hand splint on that day. She stated she had not asked anyone to put it on. She further indicated she did not feel she should have to ask staff to put her hand splint on every day, they should know. On 06/16/2022 at 10:45 AM an observation of Resident #46 revealed she did not have her left hand splint on. In an interview at that time, Resident 346 stated her left hand splint had not been put on that day. A review of the Treatment Administration Record (TAR) dated June 2022 for Resident #46 revealed documentation by Medication Technician (MT) #1 Resident #46 had her left hand splint on at 9:00 AM on 06/15/2022 and 06/16/2022. On 06/16/2022 at 11:05 AM an interview with MT #1 indicated Resident #46 had a physician's order for her left hand splint to be worn daily from 9AM-9PM. She went on to say this popped up on the TAR for her to do. She further indicated she documented Resident #46 had her left hand splint on on 06/15/2022 at 9:00 AM because she placed it on Resident #46. MT #1 stated either Resident #46 or the Nurse Aide (NA) assigned to Resident #46 that day must have taken it off after she put it on. She went on to say she documented Resident #46 had her left hand splint on 06/16/2022 at 9:00 AM but she had not actually put it on her. She stated Resident #46 was still in the shower at 9:00 AM and she had not gone back to put the splint on later. She went on to say she should not have documented she placed Resident #46's left hand splint on 06/16/2022 at 9:00 AM if she hadn't done it.	F 842	Negative findings will be addressed when/if noted by the Director of Nursing/designee. The Director of Nursing/designee will bring the results of all audits to the monthly Quality Assurance Performance Improvement (QAPI) meeting for review by the QAPI Committee for patterns/trends for 3 months. The Committee will address negative findings. Additional interventions will be developed by the Committee and implemented by the Director of Nursing, Assistant Director of Nursing/designee as needed to sustain compliance.	

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F 842	Continued From page 88 On 06/16/2022 at 5:48 PM a telephone interview with Nursing Assistant (NA) #2 indicated she cared for Resident #46 on 06/15/2022 on the 7AM-3PM shift. She stated she had not observed Resident #46 to have her left hand splint on that day. She stated she had not removed it. On 06/16/2022 at 11:11 AM an interview with the Director of Nursing (DON) indicated MT #1 should not have documented she placed Resident #46's left hand splint on 06/16/2022 if she had not done so. On 06/17/2022 at 2:40 PM an interview with the Administrator indicated MT #1 should not have documented she placed Resident #46's left hand splint on 06/16/2022 if she had not done it.	F 842		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, and physician interviews the facility ' s Quality Assessment and Assurance Committee failed to maintain and implement procedures and monitor interventions the committee put into place following the recertifications and complaint survey conducted on 6/11/21. This was for 3 deficiencies that were cited in the area of resident rights (F554, F578)	F 867	On 6/15/22 the Regional Nurse Consultant, Director of Nursing and Assistant Director of Nursing conducted a thorough round of the facility. Current resident rooms were audited to ensure there were no medications at bedside. Advanced Directives were clarified for resident #12 on 6/20/2022.	7/15/22

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F 867

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and food and nutrition services (F812) and recited on the current recertification and complaint survey of 6/17/22. The duplicate citations during 2 federal surveys of record shows a pattern of the facilities inability to sustain an effective QAA program.

Findings Included:

This tag was cross-referenced to:

1. F554 Based on observation, record review, resident, staff and physician interviews, the facility failed to assess 3 of 3 residents (Resident #20, Resident #24 and Resident #78) to determine if self-administration of medication was clinically appropriate when medication was observed to be left at the residents' bedside.

During the recertification and complaint survey 6/11/21 the facility failed to determine whether the self-administration of medications was clinically appropriate for 1 of 1 sample resident (Resident #347) who was observed to have medications at bedside.

An interview was conducted with the Administrator on 6/17/22 at 5:41 PM who stated she began at the facility in April. She stated that she and her Director of Nursing who also started at the facility in April are working to develop processes to correct current deficiencies.

2. F578 Based on record review, staff and physician interviews, the facility failed to accurately document advance directives (code status) throughout the medical record for 2 of 2 residents (Resident #12 and Resident #78) reviewed for advance directives.

F 867

Resident #295 is no longer a resident in the facility.

An audit of advanced directives/code statuses for all residents was conducted by the administrative nursing staff on 7/6/2022. All code status orders, and documentation are congruent.

On 6/13/22 the Dietary Manager (DM) discarded all unlabeled, outdated and aged produce. Items placed on the floor were removed and stored properly on the shelves in the walk-in freezer and walk in refrigerator. The DM also removed the items noted on the floor in the dry storage area and stored the item properly.

The DM and dietary aide rewashed the coffee mugs and clear plastic cups and placed upside down on metal shelves to air dry preventing wet nesting and the discolored mugs were discarded.

On 6/13/22 the Dietary Manager was educated by the Regional Director of Operations on the policy for and procedure discarding food items when out of date or not labeled, proper food storage in the walk-in refrigerator and freezer, the labeling/dating and storage of dry goods and the proper procedure for the drying of dishware and preventing of wet nesting.

On, July 11th 2022 the facility executive director completed an Ad Hoc QAPI meeting to address the areas of repeat tags mentioned in current 2567, including

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F 867	Continued From page 90 During the recertification and complaint survey 6/11/21 the facility failed to obtain a physician's order and maintain an accurate Advance Directive for 2 of 2 residents reviewed for Advance Directives (Resident #44 and Resident #9). An interview was conducted with the Administrator on 6/17/22 at 5:41 PM who stated she began at the facility in April. She stated that she and her Director of Nursing who also started at the facility in April are working to develop processes to correct current deficiencies. 3. F812 Based on observation and staff interviews the facility failed to discard expired food items stored ready for use in the reach-in and walk-in refrigerator and failed to ensure that food items in the walk-in freezer and dry storage area were not stored on the floor. The facility also failed to allow dishware to air dry before being nested for storage. This practice has the potential for cross contamination of food served to residents. This was evident in 2 of 2 kitchen observations. During the recertification and complaint survey 6/11/21 the facility failed to ensure that food items that had been opened were labeled and dated. The facility also failed to store items off the floor. This was evident in 1 of 2 kitchen observations. An interview was conducted with the Administrator on 6/17/22 at 5:41 PM who stated she began at the facility in April. She stated that she and her Director of Nursing who also started at the facility in April are working to develop processes to correct current deficiencies.	F 867	F554, F578, and F812. The committee include facility leadership team, Director of Nursing, administrative nurses, Dietary, Environmental services, Social and activities. The QAPI team reviewed the current plan of correction and responsibilities from the team on continued compliance. There were no residents identified in this alleged deficient practice. Facility Nurse Consultant completed training with the facility QAPI committee members, which included executive director, director of nursing (DON), minimum data set (MDS) nurse, dietary manager, maintenance director, medical records, and housekeeping supervisor, this included how to begin identifying other areas of quality concern through the quality improvement (QI) review process, for example: review of rounds tools, review of work orders, review American Health Tech (AHT - electronic health record), review of resident council minutes, review of resident concern logs, review of pharmacy reports, review of audits related to the plan of correction, and review of regional facility consultant recommendations. This training was completed on 7/13/22. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The Executive QAPI committee will continue to meet at a	

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F 867	Continued From page 91	F 867	minimum of quarterly, and QAPI committee monthly with oversight by a corporate staff member The QAPI committee will meet at a minimum of monthly and the Executive QAPI committee will meet a minimum of quarterly to identify issues related to quality assessment and assurance activities as needed and will develop and implementing appropriate plans of action for identified facility concerns. Facility QAPI Committee minutes will be reviewed by the RDO and/or RCN monthly for 3 months, than quarterly for 2 quarters, to ensure QAPI committee identifies and addresses the quality deficiency appropriately.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections	F 880		7/15/22

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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 corrective actions taken by the facility.

F 880 Continued From page 93

§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 1.) follow posted Contact Precautions signage by not removing Personal Protective Equipment (PPE) when exiting a resident ' s room for 1 of 1 resident (Resident #78); 2.) failed to sanitize hands when delivering lunch trays to 1 of 1 resident; 3.) failed to wear gloves when handling dirty linen. These failures occurred during the COVID-19 pandemic.

Findings Included:

A review of the Centers for Disease Control (CDC) revealed Contact Precautions mean:
"Whenever possible, patients with Methicillin-resistant Staphylococcus aureus (MRSA) will have a single room or will share a room only with someone else who also has MRSA.
Healthcare providers will put on gloves and wear a gown over their clothing while taking care of patients with MRSA.
When leaving the room, healthcare providers and visitors remove their gown and gloves and clean their hands."

Resident #78 was admitted to the facility on 06/16/2022.

F 880

On 6/17/22 R.A. #1 received 1:1 education by the Director of Nursing regarding the donning and doffing of PPE upon entering and exiting a resident who is on isolation precautions. On 6/13/22 N.A. #3 received 1:1 education by the Director of Nursing regarding the proper procedure for hand sanitizing off Relias. On 6/14/22 the Activity Director received 1:1 education by the Director of Nursing regarding the use of gloves while handling dirty linen.

On 7/1/22 the Director of Nursing, Assistant Director of Nursing and/or Staff Development Coordinator started in servicing current staff, including contract staff, on the facility infection control policy and procedure to in include donning/doffing PPE, Hand sanitizing and the handling of dirty linen off Relias. The education will be completed by 7/15/22. Newly hired staff will receive this training during orientation, including contract staff. All staff will conduct a return demonstration of donning/doffing PPE, hand hygiene and handling dirty linen starting 7/5/22 by the Director of Nursing,

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A review of Resident #78 ' s medical record revealed a physician order was written for contact precautions for MRSA on 06/16/2022 upon admission to the facility. The order was active on the date of observation, 06/17/2022.

An observation on 06/17/2022 at 9:12 am revealed Restorative Aide (RA) #1 did not remove her gloves prior to exiting the room of Resident #78.

An interview on 06/17/2022 at 9:14 am was conducted with RA #1 and revealed she did not remove her gloves or "just forgot to" when exiting Resident #78 ' s room who was on contact precautions. RA #1 stated she was providing physical therapy with Resident #78 via walker and was aware of the signage on Resident #78 ' s door for contact precautions. RA #1 stated she should have removed her gloves and sanitized her hands prior to exiting the room. She added the facility conducted frequent in-services regarding PPE and she had been trained on the use of wearing full PPE a week prior at the facility. She stated her normal practice was to follow the guidance posted on the precaution signs for each resident.

An interview with the Unit Manager on 06/17/22 09:19 AM revealed employees were required to remove PPE before leaving the room and perform hand hygiene.

An interview with the Director of Nursing (DON) on 06/17/2022 at 9:35 am revealed all staff were required to wear full PPE when entering resident ' s rooms with posted contact precaution signage and follow the instructions posted on the signage.

F 880

Assistant Director of Nursing and Staff Development Coordinator and will be completed by 7/15/22.

Infection Control surveillance audits, to include proper handwashing, handling of linens and PPE compliance, will be conducted by the Director of Nursing/designee starting on 7/11/22 to ensure the appropriate infection control policy and procedures are being followed. The audits will be conducted 5 days a week for 2 weeks and then biweekly for 10 weeks. Negative findings will be addressed when/if noted.
Facility has hired permanent Administrator, Director of Nursing, Administrative nurses and Department Managers.

The Director of Nursing/designee will bring the results of all audits to the monthly Quality Assurance Performance Improvement (QAPI) meeting for review by the QAPI Committee for patterns/trends for 3 months. The Committee will address negative findings. Additional interventions will be developed by the Committee and implemented by the Director of Nursing; Assistant Director of Nursing/designee as needed to sustain substantial compliance.

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F 880	Continued From page 95 The DON added RA #1 should have removed gloves and sanitized hands prior to exiting the room as the signage indicated. An interview with the Administrator on 06/17/2022 at 10:33 am revealed employees were required to always follow the isolation signage posted on resident ' s doors. 2. On 06/13/2022 at 12:35 PM during a continuous observation of the lunch meal service on the 600 Hall Nursing Assistant (NA) #3 was observed to remove a lunch meal tray from the meal cart. She entered a resident's room to deliver the meal tray. She was observed to place the meal tray on the bedside table, and without wearing gloves assisted the resident to transfer from the recliner chair to the wheelchair (WC) making direct physical contact with the resident. NA #3 was then observed to untangle the telephone cord from the bedside table, place the telephone on the nightstand, and reposition the resident's WC in front of the bedside table. NA #3 was observed to exit the room and without performing hand hygiene removed another meal tray from the meal cart. An interview with NA #3 at that time indicated she had not performed any hand hygiene after making direct physical contact with the resident and his environment before she removed the next meal tray from the cart. She stated she knew she should have, but she was in a hurry and had forgotten. She stated there was plenty of hand sanitizer available. She went on to say she should have performed hand hygiene	F 880		

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after resident care contact to prevent the transmission of infection.

On 06/13/2022 at 12:46 PM an interview with the Director of Nursing indicated NA #3 should have performed hand hygiene after resident contact before she removed the next meal tray from the cart.

On 06/17/2022 at 2:40 PM an interview with the Administrator indicated NA #3 should have performed hand hygiene after resident contact before she removed the next meal tray from the cart.

3. An observation of dinner trays being passed occurred on 6-14-22 at 5:18pm. The Activities Director was observed carrying a dinner tray into room 414, touching the resident's over the bed table and items on his tray. She exited room 414 without performing hand hygiene and retrieved another dinner tray. She proceeded to room 410 with the dinner tray, touching the resident's over the bed table and items on his tray. She exited room 410 without performing hand hygiene, walked to the pantry room retrieved items from the pantry room and returned to room 410. The Activities Director assisted the resident in opening the items she had retrieved from the pantry then picked up a dirty towel from the resident's floor without wearing gloves, exited room 410 with the dirty towel and not performing hand hygiene and proceeded to the soiled utility room. She was observed exiting the soiled utility room and going into the pantry.

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F 880	Continued From page 97 During an interview with the Activities Director on 6-14-22 at 5:23pm, the Activities Director stated she was not thinking about performing hand hygiene but was focused on delivering the dinner trays and providing items requested by the resident in room 410. She also stated she knew she should have put gloves on to pick up the dirty towel off the floor but again stated she was trying to hurry. The Activities Director said she had performed hand hygiene in the soiled linen room prior to going back into the pantry. She discussed receiving education on hand hygiene and infection control. A telephone interview occurred with the facility physician on 6-16-22 at 2:30pm. The physician discussed the need for staff to follow infection control protocols to prevent any spread of viruses and any breech in infection control needed to be addressed by the Director of Nursing or the Administrator. The Administrator was interviewed on 6-17-22 at 4:58pm. The Administrator discussed staff being educated on infection control practices and expected the staff to perform hand hygiene between resident contact and wear gloves when handling dirty linen.	F 880		
F 947 SS=E	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year.	F 947		7/15/22

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F 947	Continued From page 98 §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide required dementia management training for 3 of 3 current nursing staff (Nurse #4, Nursing Assistant (NA) #3 and NA #12) and failed to provide required abuse prevention training for 2 of 3 current nursing staff (Nurse #4 and NA #3). Findings included: 1.Nurse #4 was hired on 6-2-22. The facility provided Nurse #4's new hire education and education she had completed since her hire date. Upon review, it was noted Nurse #4 had not completed her dementia management training or her abuse prevention training. The Director of Nursing (DON) was interviewed on 6-17-22 at 2:30pm. The DON stated she was unaware Nurse #4 had not completed her new hire education which she stated would have included the dementia management training and abuse prevention. She also stated the education should have been completed within the first week	F 947	Nursing staff have not completed required in-service education hours. A review of staff education revealed Abuse Education and Dementia education had not always been completed on hire and/or routinely for all employees. Relias completion reports were assessed and revealed few completed in their entirety. A facility SDC was hired on 06/06/2022. The Staff Development Coordinator was educated by the Regional Nurse Consultant on required education for nursing staff on 07/01/2022. Directed education on Abuse and Neglect and Dementia training for all staff was initiated on 07/01/2022and will be completed by 7/15/2022 and on newly hired. The Staff Development Coordinator will	

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of her hire date and explained the facility did not have a staff development coordinator (SDC) during that time, so education was not being monitored.

2. NA #3 was hired on 5-26-22. The facility provided NA #3's education since her hire date. Upon review, it was noted NA #3 had not completed her dementia management training or her abuse prevention training.

The Director of Nursing (DON) was interviewed on 6-17-22 at 2:30pm. The DON stated she was unaware Na #3 had not completed her education on dementia management training and abuse prevention. She explained the facility did not have a staff development coordinator (SDC) during that time, so education was not being monitored.

3. NA #12 was hired on 10-1-14. The facility provided NA #12's education for the past year. Upon review, it was noted NA #12 had not completed her dementia management training but had completed her abuse prevention training on 1-12-22.

The Director of Nursing (DON) was interviewed on 6-17-22 at 2:30pm. The DON stated she was unaware NA #12 had not completed her education on dementia management training. She explained the facility's computerized training system and that the staff development coordinator (SDC) typically monitored the staff to ensure the education was completed. The DON stated herself and the Administrator had been responsible for monitoring the education since the facility did not have a SDC at the time.

During an interview with the Administrator on

develop an education calendar and track each employee's education hours and courses completed through The Relias Learning module and ensure that they are completed annually and on newly hired.

Staff Development nurse and/or designee will Audit 5 employees education records 3 times weekly Monday through Friday X 12 weeks.

Results of education audits will be taken to the monthly QAPI meeting x 3 months for monitoring and continue until compliance is achieved. Administrator will oversee

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F 947	Continued From page 100 6-17-22 at 4:58pm, the Administrator discussed hiring a new SDC 1 week ago (6-6-22) and planned on modifying the facility's computerized training system so staff education was completed on time.	F 947		