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F 000	INITIAL COMMENTS An unannounced complaint investigation conducted on 03/29/22 through 04/01/22. There was a total of 16 complaint allegations investigated and 4 were substantiated. NC00187583, NC00187420, NC00187354, NC00187121, NC00186679, NC00186265. Immediate Jeopardy was identified at: CFR483.25 at F 689 at a scope and severity J. Tag F689 constitued Substandard Quality of Care. Immediate Jeopardy began on 03/21/22 and was removed on 04/01/22. A partial extended survey was conducted.	F 000		
F 561 SS=E	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.	F 561		5/3/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 04/27/2022

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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§483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.

§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.
This REQUIREMENT is not met as evidenced by:
Based on observations, record review, resident, and staff interviews the facility failed to honor a resident's preference to be out of bed for an activity (Resident #5) for 1 of 1 resident reviewed and failed to honor 3 of 3 residents' preference for showers (Resident #2, Resident #7, and Resident #10).

The findings included:

1. Resident #5 was admitted to the facility on 04/04/16 with diagnoses that included non traumatic intracerebral hemorrhage.

The annual Minimum Data Set (MDS) assessment dated 01/23/22 revealed Resident #5 was cognitively intact and had no behaviors of rejection of care. The MDS also indicated that the Resident was totally dependent on staff with 2 persons assist for transfers and required a wheelchair for mobility.

A review of Resident #5's care plan dated 03/25/22 revealed the Resident was dependent on staff for meeting emotional, intellectual, social and physical needs related to physical limitations. The goal to maintain involvement in cognitive

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The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility’s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.

Corrective actions for affected residents. On March 30, 2022, the Support Nurse interviewed Resident #5 regarding his preference of getting out of bed to play Bingo. Resident #5 care plan and Kardex were updated. Residents #2, #7, and #10 were interviewed by the Support Nurse regarding their shower preferences. Resident #2, #7, and #10 care plans and Kardex were updated.
Corrective action for potentially affected residents. On April 5, 2022, the Director of Nursing/Nurse Manager began interviewing current residents regarding

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stimulation and social activities as desired would be attained by utilizing interventions such as inviting the Resident to scheduled activities, modifying daily treatment plan to accommodate preferred activities and providing activities that is of interest of Resident.

An interview and observation of Resident #5 was conducted on 03/29/22 at 12:32 PM. The Resident was lying in bed watching a small electronic device and explained that he was self sufficient with entertaining himself with his electronic devices and stated he enjoyed getting up for bingo which was offered three times a week on Monday, Wednesday and Friday.

During an observation and interview with Resident #5 on 03/30/22 at 9:55 AM the Resident was lying in bed and had just finished eating breakfast. The Resident's gown was dirty, and the Resident stated that the staff would change him when they got him up for bingo which he was looking forward to playing today at 2:00 PM.

An interview and observation were made of Resident #5 on 03/30/22 at 2:45 PM. The Resident was lying in bed wearing a clean gown. The Resident's face was red and in a shaky voice he began to explain that three nurse aides (Nurse Aides #5, #6 and #7) came into his room at around 10:20 AM and cleaned him up and put his clothes on him and even put the lift sling under him in order to be transferred to his wheelchair. The Resident stated that after they dressed him the girls told him that his aide would be in to get him up and he asked them to just transfer him to his wheelchair because it would take two people to transfer him but the girls left him in the bed. Resident #5 continued to explain that while he

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their shower preference and when they would like to get out of bed. Residents' care plan and Kardex will be updated with their preferences. Newly admitted residents will be interviewed regarding shower preference and preference of getting out of bed. Newly admitted residents care plan and Kardex will reflect preferences.
Systemic Changes. On April 5, 2022, the Director of Nursing/Nurse Manager began in-servicing all current Licensed nursing staff/Certified Nursing Assistants, to include agency staff, on where to locate Residents shower preferences and when they prefer to get out of bed. Education includes where to ascertain this information on the Kardex. The Director of Nursing/Nurse Manager will ensure all current Licensed nursing staff/Certified Nursing Assistants, to include agency staff, who have not received this education by May 3, 2022 will not be allowed to work until education is completed. The Director of Nursing/Nurse Manager will ensure newly hired staff, to include agency staff, will receive education during facility orientation in person or via telephone during prior to working.
Quality Assurance. The Director of Nursing/Nurse Manager will monitor using a Quality Assurance tool for Self-Determination related to shower preferences and getting out of bed. The monitoring will include a sample of residents regarding honoring their shower preferences and getting out of bed. The QA monitoring will be conducted three

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was eating his lunch his Nurse Aide (NA #8) came into his room and said she was ready to get him up and he asked her if he could finish his lunch first and the NA told him that while he finished his lunch that she would go eat her lunch and come back and get him up for bingo which the Resident agreed. The Resident stated that by the time the NA came back to get him up it was too late for bingo. The Resident stated the NA got help from NA #2 and undressed him and left him in the bed. Resident #5 stated he was disappointed that he missed bingo and could not understand why the three nurse aides would not transfer him to his wheelchair since they had him dressed and the lift sling under him.

An interview was conducted with Nurse Aide (NA) #8 on 03/30/22 at 2:53 PM. The NA confirmed she was taking care of Resident #5 that shift and explained that when she went in to get the Resident up the Resident was dressed in his clothes, but he was in the bed. The NA continued to explain that Resident #5 told her that 3 nurse aides came in and dressed him but would not put him in his wheelchair but told him that she would be back to get him up. The NA stated she offered to get him up then, but he was eating his lunch and asked me to come back after he finished his lunch. The NA stated she agreed and told Resident #5 that she would eat her lunch as well and come back to get him up. Nurse Aide #8 reported that when she returned from eating her lunch, she went into get the Resident up, but he refused and stated it was too late to get up because he had missed bingo. The NA stated that she and NA #2 undressed Resident #5 and left him in the bed.

On 03/30/22 at 2:55 PM an interview was

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times a week x 4 weeks, twice a week x 4 weeks, and then weekly x 4 weeks. The Director of Nursing/Nurse Manager will report the results of the QA monitoring monthly to the Quality Assurance Performance Improvement (QAPI) committee for continued compliance and/or revision.

Completion Date- 5/3/22

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conducted with Nurse Aide #5. The NA explained that she and two other nurse aides went into clean dry Resident #5 and he told them that he needed to be gotten up for bingo. The NA stated they got him dressed and told him that his nurse aide would be in to get him up for bingo. The NA was asked why they didn't get him up since he was dressed, and the NA replied that they had their residents to take care of.

An interview was conducted with Nurse #4 on 03/30/22 at 3:30 PM. The Nurse confirmed she was taking care of Resident #5 and explained that she was in the Resident's room when the three nurse aides were getting him dressed and stated she thought they were getting him up as well. The Nurse continued to explain that she did not know until after the fact that Resident #5 didn't get up for bingo but stated that the aides should have gotten him up since they were already working with the Resident.

An interview was conducted with Nurse Aide (NA) #6 on 03/31/22 at 11:20 AM. The NA confirmed that she was one of the three nurse aides who went into clean Resident #5 on 03/30/22 morning. The NA explained that the Resident told them that he needed to get up so they dressed him and got him ready but told him that his aide would come back in to get him up. When the NA was asked why they didn't get him up the NA responded that she guessed they should have since it took two people to transfer him into his wheelchair. The NA added they (the 3 aides) had their residents that they needed to be taking care of.

An interview was unable to be obtained from Nurse Aide #7.

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The Director of Nursing was unable for interview.

On 04/01/22 at 3:15 PM during an interview with the Regional Director of Clinical Services (RDCS) she stated she did not understand why the nurse aides didn't just transfer Resident #5 to his wheelchair after they got him dressed but they should have.

2. Resident #2 was admitted to the facility on 02/02/21 with diagnoses that included diabetes mellitus.

The quarterly Minimum Data Set (MDS) assessment dated 02/20/22 revealed Resident #2 was cognitively intact and had no behaviors of rejection of care. The MDS indicated the Resident required one person physical assistance with bathing and was frequently incontinent of bowels.

A review of Resident #2's Documentation Survey Report for March 2022 indicated the Resident was scheduled to receive showers on Monday and Thursday evenings. Further review of the report revealed Monday 03/28/22 was the only day Resident #2's shower was documented as given.

A review of Resident #2's medical record for the month of March 2022 revealed there was no documentation that the Resident refused his showers.

An interview was conducted with Resident #2 on 03/29/22 at 12:40 PM. The Resident explained that he received a shower yesterday (03/28/22) which was the first shower he has had in over a month. The Resident continued to explain that they asked him about his bathing preference, and

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he told them he wanted a shower two times a week but, the Resident stated, he had not been getting two showers a week.

During an interview with Resident #2 on 04/01/22 at 10:30 AM the Resident stated that no one went in to offer him a shower yesterday evening (03/31/22) therefore, he did not get his shower.

An interview was made with Nurse Aide (NA) #10 on 04/01/22 at 11:55 AM. The NA confirmed that he was assigned to give showers on hall 200 on 03/31/22 and stated he offered Resident #2 a shower, but the Resident refused. The NA verbalized that he should report shower refusals to the nurse so it could be documented but he forgot to do that.

During an interview with Unit Manager (UM) #'s 1 and 2 on 04/01/22 at 11:55 AM they explained that the facility had recently updated the shower tasks in the point of care documentation to include the residents' bathing preferences and kept the bathing schedules in a notebook at each nursing stations. UM #1 stated all staff were educated on the new process and both she and UM #2 had conducted audits to follow up on the new system. UM #1 stated they quickly discovered that some of the staff did not understand how to document in the system and that required additional education. UM #2 stated that on most shifts they had a shower team or staff dedicated to completing all the showers on that shift but if there was no shower team available then the nurse aides were responsible for completing their own scheduled showers. UM #1 added, if a resident refused a shower, it should be documented and then reported to the nurse who should find out why the resident

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refused their shower.

The Director of Nursing was unavailable for interview.

An interview conducted with the Regional Director of Clinical Services (RDCS) on 04/01/22 at 3:15 PM. The RDCS stated the facility needed to revisit the bathing preferences and explained that they were still working out the kinks in the system. The RDCS stated that she expected all resident preferences to be obtained and honored and any refusals of showers should be reported and documented.

3. Resident #7 was admitted to the facility on 01/28/21 with the diagnoses that included heart failure.
The annual Minimum Data Set (MDS) assessment dated 01/09/22 revealed Resident #7 was cognitively intact and had no behaviors of rejection of care. The MDS indicated the Resident required physical help limited to transfer only and the assistance of one staff for bathing and was occasionally incontinent of bladder and bowel.

A review of Resident #7's Documentation Survey Report for March 2022 indicated Resident #7's showers were scheduled for Monday and Thursday evenings.

A review of Resident #7's medical record revealed the Resident refused a shower on 03/28/22 after being approached twice for his shower.

An interview was conducted with Resident #7 on 03/29/22 at 3:05 PM. The Resident explained that they asked him when he wanted his showers and

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he told them the way he was supposed to be getting them was fine with him (Monday and Thursday evenings). The Resident continued to explain that he did get a shower last Thursday (03/24/22) but the staff did not consistently offer his two showers a week. The Resident stated most of the time the staff did not approach him for a shower.

During an interview with Resident #7 on 04/01/22 at 10:40 AM the Resident explained that he did not get his shower last evening (03/31/22) nor was he approached about his shower.

A review of the daily assignment sheet for Thursday 03/31/22 revealed Nurse Aide (NA) #10 was scheduled to give showers for hall 200 for the evening shift.

An interview was made with Nurse Aide (NA) #10 on 04/01/22 at 11:55 AM. The NA confirmed that he was assigned to give showers on 03/31/22 and offered Resident #7 a shower but the Resident refused. The NA verbalized that he should report shower refusals to the nurse so it could be documented and stated he forgot to do that.

During an interview with Unit Manager (UM) #'s 1 and 2 on 04/01/22 at 11:55 AM they explained that the facility had recently updated the shower tasks in the point of care documentation to include the residents' bathing preferences and kept the bathing schedules in a notebook at each nursing stations. UM #1 stated all staff were educated on the new process and both she and UM #2 had conducted audits to follow up on the new system. UM #1 stated they quickly discovered that some of the staff did not

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understand how to document in the system and that required addition education. UM #2 stated that on most shifts they had a shower team or staff dedicated to completing all the showers on that shift but if there was no shower team available then the nurse aides were responsible for completing their own scheduled showers. UM #1 added, if a resident refused a shower, it should be documented and then reported to the nurse who should find out why the resident refused their shower.

The Director of Nursing was unavailable for interview.

An interview was conducted with the Regional Director of Clinical Services (RDCS) on 04/01/22 at 3:15 PM. The RDCS stated the facility needed to revisit the bathing preferences and explained that they were still working out the kinks in the system. The RDCS stated that she expected all resident preferences to be obtained and honored and any refusals of showers should be reported and documented.

4. Resident #10 was readmitted to the facility on 04/02/21.

Review of the Annual Minimum Data Set (MDS) dated 10/02/21 revealed that Resident #10 was cognitively intact for daily decision making and required one person assistance with bathing. The MDS further revealed that it was very important to Resident #10 to choose between a tub bath, shower, bed bath, or sponge bath.

Review of Resident #10's Documentation Survey report dated 03/01/22 through 03/31/22 indicated that Resident #10 was scheduled to receive a

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F 561	Continued From page 10 shower on Monday and Thursday on second shift. Further review of the report indicated that on Monday 03/28/22 and Thursday 03/31/22 no initials were on the form indicating the showers had not been provided. Review of the schedule dated 03/28/22 indicated that Nurse Aide (NA) #2 was responsible for showers on the unit where Resident #10 resided. During a resident council meeting on 03/29/22 at 2:40 PM Resident #10 reported that she was supposed to get a shower twice a week and stated, "I get one occasionally." Resident #10 stated if "I don't get a shower no one gives me a bed bath either." The NA that was assigned to Resident #10 on 03/31/22 was unable to be verified and the facility was unable to provide evidence that Resident #10 had received her shower. NA #2 was interviewed on 03/30/22 at 12:20 PM. NA #2 stated that he worked at the facility through an agency and confirmed that he worked on 03/28/22. He could not recall what unit he was working that day but stated if he had given Resident #10 a shower, he would have documented it in the point of care system. NA #2 added that he did not believe Resident #10's showers were due on his shift. A follow up interview was conducted with Resident #10 on 03/30/22 at 5:38 PM. Resident #10 stated she preferred showers over bed baths and wanted a shower twice a week and not early in the morning. Resident #10 pointed directly across the hall to the shower room and stated, "I only get my showers occasionally and there is no	F 561		

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F 561	Continued From page 11 rhyme or reason to it." Resident #10 confirmed that she did not receive a shower on Monday 03/28/22. Unit Manager (UM) #1 and #2 were interviewed on 04/01/22 at 11:56 AM. UM #1 stated that the facility had recently updated the shower task in the point of care documentation to include the resident bathing preferences and kept the bathing schedule in a book at each nursing station. UM #1 stated that all nursing staff were educated on the process and she and UM #2 had conducted the audits and follow up on the system. UM #1 stated that they quickly discovered that some of the staff did not understand how to document in the system and that required additional education. UM #2 stated that on most shift they had a shower team or staff dedicated to completing all the showers on that shift but if there was no shower team then the NAs were responsible for completing their own assigned showers. UM #1 added if a resident refused a shower, it should be documented and then reported to the nurse who should find out why the resident refused the shower. The Director of Nursing (DON) was unavailable for interview on 04/01/22. The Regional Director of Clinical Services (RDCS) was interviewed on 04/01/22 at 3:14 PM. The RDCS stated the "facility needed to revisit the preferences" and explained they were still working out the kinks in the system. The RDCS stated she expected all preferences to be obtained and honored and any refusals of showers to be documented.	F 561		
F 565 SS=D	Resident/Family Group and Response	F 565		5/3/22

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F 565	Continued From page 12 CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident,	F 565	F565	

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F 565	Continued From page 13 and staff interview the facility failed to follow up on and respond to grievances voiced in resident council for 1 of 1 resident council meeting (02/24/22). The findings included: Review of the 02/24/22 resident council meeting minutes revealed that the resident council had concerns with the dietary department that included: food not hot, not getting condiments on tray, wrong silverware being sent on trays, and no snacks available in nourishment rooms. During an observation of the resident council meeting held on 03/29/22 at 2:30 PM with 7 residents in attendance revealed that no follow up had been provided to the resident council from the dietary department from the 02/24/22 resident council meeting. The other department concerns and follow up were read to the council by the Activity Director (AD). The resident council president (Resident #12) continued to voice concerns with their food not being hot, not getting condiments on their tray, receiving the wrong silverware with their meal, and having no snacks available. The AD was interviewed on 03/29/22 at 2:40 PM. The AD stated that after the 02/24/22 resident council meeting she had written up all the concerns and handed them to the appropriate department head to handle. She stated that before the 03/29/22 meeting she went around and asked for the follow up from the concerns and if the department head did not have the follow up, she would check back with them again before the meeting. The AD confirmed that she had asked the Dietary Manager (DM) for the	F 565	Corrective actions for affected residents. On April 18, 2022, a follow-up response to the Resident Council's grievance from meetings held on February 24, 2022, was obtained. This response will be presented to the Resident Council meeting to be held April 2022. Corrective action for potentially affected residents. On April 21, 2022, the Administrator reviewed the Resident Council minutes from January, February and March 2022 and no other outstanding Resident Council grievances were noted. Systemic Changes. The Administrator/Activity Director began in-servicing all Department heads on Resident/Family group and response. The education consists of timely completion of Resident Council meeting grievance resolution forms. The Activity Director/Assistant Activity Director will communicate any grievances in the Department head meeting following the Resident Council monthly meeting, to ensure resolution by the Administrator. The Activity Director/Assistant Activity Director will complete a Resident Council grievance resolution form detailing the grievance communicated and assign to the appropriate department for follow-up and resolution. A copy of the initiated form will be maintained in the Resident Council meeting book until complete. Each department will provide a written response as to how the grievance was resolved and return the completed form to the Activity	

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F 565	Continued From page 14 follow up and none had been provided to her, so the same concerns voiced in the 02/24/22 meeting were again voiced on the 03/29/22 meeting. A follow up interview was conducted with Resident #12 on 03/30/21 at 3:32 PM. Resident #12 stated that she personally had issues with her food not being served hot and had been served a fork with cereal. She stated that a lot of residents had voiced concerns to her as the resident council president that they had the same issues along with not getting condiments like salt/pepper on their tray and the lack of available snacks. She stated that they had voiced the concerns in the resident council meeting on 02/24/22 but when they council met on 03/29/22 there was no follow up or resolution provided to the council and she confirmed that the issues were ongoing. The DM was interviewed on 03/31/22 at 10:41 AM. The DM confirmed that she had received the concerns from the 02/24/22 resident council meeting from the AD but stated she had not followed up on them yet because she had not had the time. The DM stated that the AD did come and ask her for the follow up, but she had not had the time to complete it, so she did not give the AD anything to present to the council. An interview was conducted with the Administrator on 04/01/22 at 6:19 PM. The Administrator stated that after each resident council meeting the AD would write up the concerns from the council and give to the appropriate department head for follow up. She added that "generally she made sure the concerns were followed up on." She stated she	F 565	Director/Assistant Activity Director. The Activity Director/Assistant Activity Director will provide the Resident Council minutes, along with the grievance resolution forms to the Administrator monthly for review. The grievance resolution forms will be communicated in the subsequent Resident Council meeting. The Administrator/Activity Director will ensure all Department heads, to include agency, who has not received this education by May 3, 2022, will not be allowed to work until education is complete. Any newly hired Department head will receive education during facility orientation in-person or via telephone prior to working. Quality Assurance. The Administrator/Activity Director/Director of Nursing will monitor using a Quality Assurance tool for Resident/Family group and response. The monitoring will audit Resident Council minutes to include the resolution of grievances. The QA monitoring will be conducted monthly times three months. The Administrator/Director of Nursing will report the results of the QA monitoring to the Quality Assurance Performance Improvement (QAPI) committee for continued compliance and/or revision. Completion Date- 5/3/22	

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F 565	Continued From page 15 had been off of work for 11 days over the past month and had not had the time to ensure the concerns had been followed up on. The Administrator stated that she expected all concerns voiced in resident council to be addressed and a response given to the resident council for resolution.	F 565		
F 568 SS=D	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii) §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, the facility failed to maintain an accurate accounting of the Resident Council funds that reflected when all transactions occurred and a detailed itemization for each transaction for 1 of 1 Resident Council fund reviewed. Findings included: During an interview on 03/29/22 at 12:13 PM, the Resident Council President (RCP) revealed a community group raised money for the Resident	F 568	Corrective actions for affected residents. The facility was unable to locate funds and maintain accurate accounting of Resident Council funds. Corrective action for potentially affected residents. On April 7, 2022, the Activity Director met with the Resident Council President accounting for current fundraiser funds in the amount of $77.35 The Business Office Manager set up a separate account in RFMS for fundraiser funds. A money order will be obtained and	5/3/22

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Council by holding a car show at the facility which included food, a live band and merchandise for sale. The RCP recalled the last fundraiser held was prior to the start of the COVID-19 pandemic and the money collected and presented to her totaled approximately $2,400.00. The RCP stated she gave the money to the previous Activities Director (AD) and assumed the AD placed the money into an account. The RCP explained at the request of the Resident Council group, the previous AD used some of the money to purchase a grill for approximately $800.00; however, when she recently inquired on the balance, she was told by the current Business Office Manager (BOM) there was none.

During an interview on 03/29/22 at 1:01 PM, the BOM revealed she had been in the position for two and a half weeks and was responsible for managing resident trust fund accounts. The BOM stated prior to her starting the position, it was her understanding the Resident Council had money that was kept in the facility safe but was unable to recall the amount. The BOM explained when a resident inquired on the balance of the Resident Council funds, she checked the safe and could not locate any money for Resident Council. The BOM stated when she spoke with the previous AD to inquire of the funds, she was told the Resident Council money was used to purchase a grill for the residents and any money that was left over would be in the safe. The BOM stated she would assume the funds raised by Resident Council should be set up as a resident trust fund account and had spoken with the corporate office to inquire about setting one up. The BOM stated currently, the Resident Council money earned from cookie and ornament sales was kept by the AD in a locked box in the activity

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deposited into the RFMS account.

Systemic Changes. On April 25, 2022, the Administrator educated the Activities Director and staff on accounting and records of personal funds from fundraisers. Newly hired activity department staff will receive education during orientation. Resident Council funds from fundraisers will deposited into the RFMS account. The Activities Director/Activity Assistant will review Resident Council fundraiser statement balances monthly in Resident Council Meetings.

Quality Assurance. The Administrator/Business Office Manager will monitor using a Quality Assurance tool for accounting and records of personal funds. The monitoring will audit Resident Council fundraiser statements. The QA monitoring will be conducted monthly x three months. The Administrator/Business Office Manager will report the results of the QA monitoring to the Quality Assurance Performance Improvement (QAPI) committee for continued compliance and/or revision.

Copletion Date- 5/3/22

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office.

During an interview on 03/29/22 at 12:43 PM, the former BOM revealed when she left employment in May 2021, the Resident Council had approximately $1,500.00 in cash left after purchasing a grill that was kept in the facility safe.

During an interview on 03/30/22 4:03 PM, the previous AD revealed there had not been a car show fundraiser in years due to the COVID-19 pandemic. The previous AD recalled sometime last summer Resident Council voted to have her purchase a new grill using the Resident Council funds. She was unable to recall how much money was available in the fund at the time but recalled the grill and cover cost approximately $1,000.00 which took most of what was left. The previous AD explained the Resident Council money was kept in an envelope locked in the facility safe and every time money was taken out, the amount was written on the envelope. The previous AD stated she really had no idea where the money went or how much money was left.

During an observation on 03/30/22 9:18 AM, the Activities Assistant counted the Resident Council money being kept in the activity office. The money was in an unlocked box and totaled $64.00 and some change. There was no document to review that described how much money was deposited or withdrawn.

During a follow-up interview on 03/30/22 at 3:30 PM, the BOM stated she spoke with the corporate office and was informed they were unable to generate an account for Resident Council funds in the facility accounting program because the account had to be associated with a social

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F 568	Continued From page 18 security number. The BOM was unaware of any procedure the facility had for the accounting of Resident Council funds. During an interview on 03/31/22 at 4:50 PM, the Administrator revealed she knew of the fundraiser for Resident Council but was not aware there was money left over from that event. The Administrator stated the fundraiser was prior to her starting employment at the facility and she could not speak to what may or may not have happened to the funds. The Administrator explained Resident Council funds were not mixed in with individual resident trust fund accounts and there was not a separate account in the facility's accounting program for Resident Council. The Administrator stated any money currently raised by the Resident Council was being kept by the AD in a locked box. The Administrator stated the funds managed by the facility for Resident Council should include a document with a running total of the balance that accounted for all deposits and withdrawals.	F 568		
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	F 686		5/3/22

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promote healing, prevent infection and prevent new ulcers from developing.
This REQUIREMENT is not met as evidenced by:
Based on observations, record reviews and interviews the facility failed to implement a Physician order to apply heel protectors to a deep tissue injury for 1 of 3 residents reviewed for pressure ulcers (Resident #20).

The finding included:

Resident #20 was admitted to the facility on 12/11/21 with diagnoses that included urinary tract infection and cerebral vascular accident.

Resident #20's care plan initiated 02/08/22 indicated she had an unstageable area on her left heel with the goal that the Resident would have no further skin breakdown and the current area would show improvement by the next review. The interventions utilized included weekly skin assessments, providing treatments as ordered and consult with the Wound Physician.

A review of Resident #20's medical record revealed a Wound Physician progress note dated 03/03/22 that indicated the left heel deep tissue injury measured 1centimeter (cm) x 1.5 cm and 1.5 square cm with 100% epithelial. The progress notes also indicated the deep tissue injury was improving.

A review of Resident #20's medical record revealed a Physician order dated 03/10/22 that indicated the Resident was to wear heel boots at all times when the Resident was in bed.

A review of Resident #20's medical record

F 686

Corrective actions for affected residents. On March 30, 2022, the Support Nurse applied heel protectors to Resident #20. April 18, 2022, the Wound Nurse assessed Resident #20 bilateral heels. No redness or open areas noted. On April _18_, 2022, Physician orders were written to discontinue heel protectors for Resident #20.

Corrective action for potentially affected residents. On April 18, 2022, the Wound Nurse began auditing current residents with Physician orders for heel protectors. Residents' Kardex reviewed ensuring delegation as a Certified Nursing Assistant task. An assessment of current Residents' heels will be performed to ensure appropriate treatment for preventing and healing pressure ulcers are in place. Resident's care plan will be updated and Kardex displaying tasks for Certified Nursing Assistants direct care staff.

Systemic Changes. On April 5, 2022, the Director of Nursing/Nurse Manager began in-servicing all current Licensed nursing staff/Certified Nursing Assistants, to include agency staff, on treatment and services to prevent/heal Pressure Ulcers. In-servicing Education includes Licensed staff following physician orders on the Treatment Administration Records and Certified Nursing Assistant tasks on

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F 686	Continued From page 20 revealed the Resident was seen weekly by the Wound Physician (WP) starting 02/09/22. On 03/10/22 a progress note written by the WP indicated Resident #20 had a deep tissue injury to the left heel and the Resident was to wear heel boots at all times while in bed. This progress note gives no size or appearance or no comments about improving, just says to wear heel boots while in bed. There might have been documentation on the next weekly WP note but I did not get it because I thought her heel looked good when I saw it. The quarterly Minimum Data Set (MDS) assessment dated 03/18/22 revealed Resident #20's cognition was severely impaired and required extensive assistance with bed mobility. The MDS also indicated the Resident was incontinent and was at risk for developing pressure ulcers. On 03/29/22 at 10:30 AM an observation was made of Resident #20 in bed, lying on her back sleeping. The Resident's heels were positioned on the bed against the mattress without heel protectors on nor were there heel protectors observed in the Resident's room. On 03/29/22 at 2:55 PM an observation was made of Resident #20 in bed sleeping while lying on her back. The Resident's heels were stationed on the bed against the mattress and without wearing heel protectors. There were no heel protectors observed in the Resident's room. On 03/30/22 at 9:56 AM an observation of Resident #20 was made of the Resident lying in bed on her right side with her heels flush against the mattress and not wearing heel protectors nor	F 686	Kardex. The Director of Nursing/Nurse Manager will ensure all current Licensed nursing staff/Certified Nursing Assistants, to include agency staff, who have not received this education by May 3, 2022, will not be allowed to work until education is completed. The Director of Nursing/Nurse Manager will ensure newly hired staff, to include agency staff, will receive education during facility orientation in person or via telephone during prior to working. Quality Assurance. The Director of Nursing/Nurse Manager will monitor using a Quality Assurance tool. The monitoring will include a sample of residents with Physician orders for heel protectors, CNA task delegation and resident application. The QA monitoring will be conducted three times a week x 4 weeks, twice a week x 4 weeks, and then weekly x 4 weeks. The Director of Nursing/Nurse Manager will report the results of the QA monitoring monthly to the Quality Assurance Performance Improvement (QAPI) committee for continued compliance and/or revision. Completion Date- 5/3/22	

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were there heel protectors observed in the Resident's room.

On 03/30/22 at 10:10 AM an observation was made of Resident #20 with Nurse Aide (NA) #3 present. The Resident was lying in bed with her heels on the bed and not wearing heel protectors. Observation of Resident #20's left heel was that the heel was dry, scaly and no redness or open areas noted. Observation of the right heel was the same as the left heel. There was no evidence of a deep tissue injury. There were no heel protectors observed in the Resident's room.

An interview was conducted with Nurse Aide #3 on 03/30/22 at 10:10 AM who was responsible for Resident #20 that shift. The NA acknowledged that Resident #20 was not wearing heel protectors and explained that the nurse aides were made aware of the residents' assistive devices through word of mouth by therapy or other nursing staff. The NA continued to explain that if she had noticed heel protectors in Resident #20's room then she would have known that she needed to put the heel protectors on the Resident but stated she did not notice heel protectors in the Resident's room.

On 03/30/22 at 10:45 AM during an interview with Nurse #4 she confirmed that she was responsible for Resident #20 on that shift. The Nurse explained that if Resident #20 had an order for heel protectors then the nurse aides should put the heel protectors on the Resident. The Nurse continued to explain that the order should be on the Resident's point of care in the computer so the nurse aides would know to put the heel protectors on the Resident. Nurse #4 looked for the order on Resident #20's point of care and

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stated the order was not there.

On 03/30/22 at 12:20 PM an interview was conducted with Nurse Aide (NA) #4 who confirmed she cared for Resident #20 on 03/29/22 from 7:00 AM to 3:00 PM. The NA explained that she did not apply heel protectors on Resident #20 during her shift on 03/29/22 because she was not aware that the Resident needed to wear the heel protectors. The NA continued to explain that the therapy staff applied the residents' assistive devices.

An observation of Resident #20 on 03/30/22 at 1:30 PM revealed the Resident was in bed sleeping with heel protectors on both feet.

An interview was conducted with Nurse #5 on 03/31/22 at 11:00 AM who confirmed that he cared for Resident #20 on 03/29/22 from 7:00 AM to 7:00 PM. The Nurse explained that Resident #20 had an order for heel protectors to be worn at all times while the Resident was in bed, but he could not remember if the Resident had the heel protectors on during his shift on 03/29/22. The Nurse stated that either himself or the nurse aide should have made sure the Resident had the heel protectors on while she was in the bed.

On 04/01/22 at 10:50 AM an interview was conducted with Unit Manager (UM) #1. The UM explained that the order for Resident #20 to wear heel protectors at all times while in bed should be on the Treatment Administration Record (TAR) for the nurses to initial or the plan of care on the computer for the nurse aides to initial. Either way, the UM stated, Resident #20 should have had heel protectors on while she was in the bed.

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F 686	Continued From page 23 An interview was conducted with the Regional Director of Clinical Services (RDCS) on 04/01/22 at 3:15 PM. The RDCS explained that her expectation was that all orders for assistive devices such as heel protectors be put on the residents' plan of care in the computer for the nurse aides and on the residents' Treatment Administration Record for the nurses to follow up and assure the assistive devices were being applied as ordered. During an interview with the Administrator on 04/01/22 at 6:20 PM the Administrator stated she expected the residents' heel protectors be applied as ordered.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by:	F 688		5/3/22

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Based on observations, record review, and staff interview the facility failed to apply a hand splint (Resident #4 and Resident #3) per the functional maintenance program for 2 of 2 residents reviewed with limited range of motion.

The findings included:

1. Resident #4 was readmitted to the facility on 04/23/20 with diagnoses that included dementia, heart disease, and others.

Review of a physician order dated 11/22/21 read in part; T-bar splint to left hand.

Review of the quarterly Minimum Data Set (MDS) dated 01/23/22 indicated that Resident #4 had severely impaired cognition and required extensive to total assistance with activities of daily living.

An observation of Resident #4's room was made on 03/29/22 at 11:05 AM. There was a sign posted at the head of Resident #4's bed that stated see splinting instructions on inside of resident closet. The splinting information on the closet read in part, -assess skin for breakdown and complete left-hand hygiene, -complete range of motion with left digits in extension, -don T bar splint at 7:00 AM, -doff at 7:00 PM, -check skin for skin breakdown, -notify the nurse immediately if skin breakdown is noted. The instructions included detailed pictures of the splint on Resident #4. Resident #4 did not have any splint in place at the time of the observation. Resident #4 did have a palm guard in his left hand.

An observation of Resident #4 was made on 03/30/22 at 9:10 AM. Resident #4 was resting in

F 688

Corrective actions for affected residents. On March 30, 2022, the Support Nurse went to Resident #4 room and removed left hand palm guard and applied Resident's left hand T-bar splint. March 30, 2022, Resident #4 was re-evaluated by therapy for splint to left hand. On March 30, 2022, Resident #4 Physician orders for left hand T-bar splint were updated. Resident #4 care plan was updated and Kardex CNA task delegation noted.
On April 18, 2022, Resident #3 was evaluated by therapy and Physician clarification orders were written. Resident #3 care plan and Kardex CNA task delegation were updated reflecting updates.

Corrective action for potentially affected residents. On April 18, 2022, the Rehab Director began auditing current residents with Physician orders for splints to ensure treatment and services are in place to ensure an increase of range of motion and/or prevent further decrease in range of motion. Identified Residents will be evaluated by therapy. Resident's Physician orders, care plan and Kardex delegating tasks for Certified Nursing Assistants will be updated.

Systemic Changes. On April 5, 2022, the Director of Nursing/Nurse Manager began in-servicing all current Licensed nursing staff/Certified Nursing Assistants, to include agency staff, on increasing and preventing further decrease in the range of motion. In-servicing Education includes

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bed with his head of bed elevated. He was observed to have no splint to his left hand in place and was being assisted with the breakfast meal by Nurse Aide (NA) #2. Resident #4 did have a palm guard in his left hand.

An observation of Resident #4 was made on 03/30/22 at 11:08 AM. Resident #4 was resting in bed with his head of bed elevated. He was observed to have no splint to his left hand. Resident #4 did have a palm guard in his left hand.

NA #2 was interviewed on 03/30/22 at 12:20 PM. NA #2 confirmed that he was caring for Resident #4 and stated this was the first time he had ever cared for Resident #4. NA #2 stated that he knew nothing about any splint or splinting schedule that Resident #4 had. He stated that NA #1 was his usual care giver and maybe she was aware of Resident #4's splint.

NA #1 was interviewed on 03/30/22 at 12:42 PM. NA #1 confirmed that she routinely cared for Resident #4 but had been pulled to do other duties. She stated that it had been "sometime" since she had seen Resident #4 wear a splint to his left hand. She stated that she really did not know about his splinting schedule because it "was confusing" and she assumed that therapy was applying the splint when he needed it.

An observation of Resident #4 was made on 03/30/22 at 2:35 PM. Resident #4 was resting in bed with his eyes closed. He was noted to have a palm guard in his left hand, but no splint was noted in place per the functional maintenance plan posted in his room.

F 688

Licensed staff following physician orders on the Treatment Administration Records ensuring Kardex tasks by Certified Nursing Assistant are implemented. The Director of Nursing/Nurse Manager will ensure all current Licensed nursing staff and Certified Nursing Assistants, to include agency staff, who have not received this education by May 3, 2022, will not be allowed to work until education is completed. The Director of Nursing/Nurse Manager will ensure newly hired staff, to include agency staff, will receive education during facility orientation in person or via telephone during prior to working.

Quality Assurance. The Director of Nursing/Nurse Manager will monitor using a Quality Assurance tool. The monitoring will include a sample of residents with Physician orders for splints, Kardex CNA task delegation and observation of splint application on Resident. The QA monitoring will be conducted three times a week x 4 weeks, twice a week x 4 weeks, and then weekly x 4 weeks. The Director of Nursing/Nurse Manager will report the results of the QA monitoring monthly to the Quality Assurance Performance Improvement (QAPI) committee for continued compliance and/or revision.

Completion Date- 5/3/22

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The Occupational Therapist (OT) was interviewed on 03/30/22 at 2:45 PM. The OT stated that he had not treated Resident #4 for over a year and was not sure if the T-bar splint was still appropriate or not and indicated that would require a new evaluation. The OT stated that the new evaluation would determine if Resident #4 could still wear the T-bar splint or not and determine the status of his left-hand contracture.

The Rehab Director (RD) was interviewed on 03/31/22 at 2:54 PM. The RD stated that Resident #4 had not been screened by therapy since 08/03/21. She stated that she had only been at the facility for 3 weeks but ideally, she preferred her residents be screened for any functional changes every quarter. She stated that Resident #4 would require a new therapy evaluation to determine if the T-bar splint was still effective or not.

Unit Manager (UM) #1 was interviewed on 04/01/22 at 11:56 AM. UM #1 stated that when a resident was finished therapy, they were sometimes placed on a functional maintenance plan that the nursing staff was responsible for carrying out. She stated that the therapy department made sure the nursing staff was educated on the application process and schedule and then they would generally post it in the resident room. UM #1 stated that the NAs should be applying the splint per the functional maintenance plan as posted in Resident #4's room and if they had any questions, they should have asked the nurse or the therapy department for clarification.

The Director of Nursing (DON) was unavailable for interview on 04/01/22.

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The Regional Director of Clinical Services (RDCS) was interviewed on 04/01/22 at 3:14 PM. The RCDS stated that the facility had a new RD and she had asked her to take over the splint process in the facility. She added that if therapy discontinued a resident, then the splitting program should be passed to the nursing staff for application. The RDCS stated she expected Resident #4's split to be applied as instructed in the functional maintenance plan posted in his room.

2. Resident #3 was admitted to the facility on 12/13/20 with diagnoses that included heart failure, diabetes mellitus and chronic obstructive pulmonary disease.

The annual Minimum Data Set (MDS) assessment dated 01/09/22 revealed Resident #3 was cognitively intact and had no behaviors of rejection of care. The Resident required extensive assistance with activities of daily living and had no impairment in her upper extremities.

A review of Resident #3's Physician's order dated 03/22/22 read: Patient to wear right palm guard splint up to 16 hours daily with frequent skin checks. Hand hygiene to be performed before donning splint. Perform gentle range of motion (ROM) to all digits prior to donning splint as tolerated.

A review of Resident #3's Physician order dated 03/23/22 read: Patient to wear right T-Bar splint (dark blue) up to 8 hours daily with frequent skin checks. Hand hygiene to be performed before donning splint. Perform gentle ROM to all digits

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prior to donning splint as tolerated.

An observation of a sign posted above Resident #3's bed with directions to see splinting instructions inside closet door.

The directions for the splints instructed:

1) Complete left-hand hygiene and ROM in extension, don left T bar splint, Resident to wear T bar from 7 am - 3 pm, doff splint and assess skin for breakdown and notify nurse immediately if any skin breakdown is noted.

2) Complete right hand hygiene, don right palm guard at 7 am, doff at 3 pm, check skin for skin breakdown and notify nurse immediately if skin breakdown is noted.

An observation of Resident #3 on 03/29/22 at 10:35 AM revealed the Resident was lying in bed sleeping. During the observation the Resident was not wearing a left-hand splint, nor was the Resident wearing a right palm guard. There was, however, a blue right-hand splint lying under the head of Resident #3's bed on the floor.

On 03/29/22 at 2:55 PM an observation was made of Resident #3 lying in bed sleeping and she was not wearing any splints on her hands. The blue right hand splint was still on the floor under the head of the bed.

During an observation and interview with Resident #3 on 03/30/22 at 10:25 AM the Resident was lying in bed awake and when asked if she had been wearing her hand splints she replied "no" and shook her head no. An observation was made of the blue right-hand

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splint that remained on the floor under the head of the Resident's bed.

On 03/30/22 at 12:20 PM an interview was conducted with Nurse Aide (NA) #4 who confirmed she took care of Resident #3 on 03/29/22 from 7:00 AM to 3:00 PM. The NA explained that she was aware that Resident #3 wore splints because there was a sign posted on the wall above her bed. The NA continued to explain that she had never seen splints on Resident #3 and thought therapy was responsible for applying the residents' splints.

On 03/30/22 at 1:30 PM during an observation of Resident #3 the Resident was in the bed sleeping and not wearing hand splints. The blue hand splint remained on the floor under the Resident's bed.

During an interview with Nurse Aide (NA) #3 on 03/30/22 at 4:55 PM the NA confirmed she was currently taking care of Resident #3 for that shift. The NA explained that she thought the therapy department applied the residents' splints and thought Resident #3 was wearing the splints.

An interview was conducted with Nurse #4 on 03/30/22 at 5:00 PM. The Nurse confirmed she was currently taking care of Resident #3 for that shift and explained that the nurse aides should apply the resident's splints in the morning as they gave the residents morning care. The Nurse stated she should have checked behind the nurse aide to ensure the she applied the Resident's splints.

On 03/30/22 at 11:00 AM during an interview with Nurse #5 the Nurse confirmed he worked with

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Resident #3 on 03/29/22 from 7:00 AM - 7:00 PM. The Nurse explained that he was aware that Resident #3 wore splints but stated the splints were applied by the therapy department. The Nurse showed the Surveyor that the order for the Resident's splints were set up on the Treatment Administration Record (TAR) and were to be applied by therapy.

An interview was conducted with the Rehab Manager (RM) on 03/31/22 at 2:55 PM who explained that Resident #3 was on Occupational Therapy (OT) caseload until 02/07/22 when she was discontinued due to transitioning to Hospice services and therefore did not complete the treatment plan for splinting. When the RM was asked about the splint orders being set up on the TAR for therapy staff to apply the splints she responded that she did not know anything about that and added that it was discussed in clinical stand up that she would be discharged from skilled therapies because of being transitioned to Hospice services. The RM stated she had no knowledge of the current splint orders for Resident #3.

During an interview with the Hospice Nurse (HN) on 03/31/22 at 4:30 PM she elaborated to say that Resident #3 was picked up for Hospice services on 02/03/22 with the order for a right hand splint for 8 hours a day and a right palm guard splint for 16 hours a day. The HN stated they expected the splint orders to be active and should be carried out.

The Director of Nursing was unavailable for interview.

During an interview with the Regional Director of

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F 688	Continued From page 31 Clinical Services (RDCS) on 04/01/22 at 3:15 PM she explained that the facility had a new Rehab Manager (RM) who was asked to take over the splint process in the facility. She continued to explain that when Resident #3 was transitioned to Hospice services, the order should have been written for a functional maintenance program for the splints and the nursing staff should have been responsible for applying the splints. An interview was conducted with the Administrator on 04/01/22 at 6:20 PM. The Administrator stated that it was her expectation for the residents' splints to be applied as ordered by the Physician.	F 688		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident and staff interviews, the facility staff failed to respond to a door alarm and prevent a resident with severe cognitive impairment from exiting the facility unsupervised (Resident #1). According to security footage Resident #1 exited the facility on 3/21/22 at 5:24 AM and was let back into the facility at 6:15 AM. Nurse #1 did not report the incident to anyone and did not put any interventions in place to prevent Resident #1 from	F 689	F689 Corrective actions for affected residents. On March 21, 2022, Resident #1 was placed on one-to-one observation 24 hours/day until discharging to a locked unit on April 12, 2022. Resident #1 care plan updated. On March 29, 2022, Nurse Aide #4 reentered Resident #20□s room and remained bedside while bed in the highest position. On March 29, 2022,	5/3/22

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exiting the facility. As a result, Resident #1 exited the facility unsupervised through the same door, at an undetermined time, later that same morning. The facility also failed to implement fall precautions and supervise a resident (Resident #20) at risk for falls when the resident was left unattended in a bed raised to the highest position. This affected 2 of 3 residents reviewed for accidents.

Immediate Jeopardy began on 03/21/22 when Resident #1, who had severe cognitive impairment, exited the facility through an emergency exit door located at the end of the 100 hall and remained outside unsupervised. The immediate jeopardy was removed on 04/01/22 when the facility provided and implemented an acceptable credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity of a D (isolated with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective related to supervision to prevent accidents.

The facility was also cited at a scope and severity of "D" for example #2 (Resident #20).

The findings included:

Resident #1 was admitted to the facility on 01/24/22 with diagnoses that included vascular dementia, insomnia, and mood disorder.

Resident #1's admission wandering assessment dated 01/26/22 assessed Resident #1 to be a low wandering risk.

F 689

Director of Nursing provided education to Nurse Aide #4. Resident #20 care plan was updated and tasked on the Kardex.

Corrective action for potentially affected residents. On March 21, 2022, the Director of Nursing, Unit Coordinators, and Regional Director of Clinical Services completed an audit of current cognitively impaired Residents with exit seeking and wandering behaviors from their most recent wandering risk assessment and high risk for elopement. The Director of Nursing/Nurse Manager reviewed all current Residents at risk for falls. Residents care plans reviewed for appropriate interventions and tasks reflected on their Kardex. By March 30, 2022, the Maintenance Director and Maintenance Assistant checked current Residents beds for functionality.

Systemic Changes. On March 31, 2022, the Maintenance Director inspected all exit doors for functionality and stop buttons weren□t engaged. None identified. On March 31, 2022, the Administrator and Maintenance Director conducted an elopement drill. On March 31, 2022, the door company inspected all facility doors for proper functioning and alarm audible levels. On April 1, 2022, the Maintenance Director and Maintenance Assistant installed secondary doors alarms requiring manual key disabling and educated staff. Monthly elopement drills on various shifts will be conducted by the Maintenance Director. Inspection of the wanderguard system and door alarms

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A review of Resident #1's admission Minimum Data Set assessment dated 01/30/22 revealed Resident #1 had severe cognitive impairment. Resident #1 was coded with wandering behaviors occurring 1-3 days during the 7-day lookback.

There was no care plan for wandering initiated when the admission MDS was completed.

During an interview with Nurse Aide #12 on 03/30/22 at 4:23 PM, she reported she was working 3rd shift from 03/20/22 into 03/21/22. She stated she remembered being in a resident's room assisting them with getting ready for a medical appointment when she heard someone say there was a resident outside. Nurse Aide #12 reported she went to the hallway and noted that Resident #1 was at the door with a nurse, and she ran to get Nurse #8. She could not recall who the nurse was with Resident #1 at the door. Nurse Aide #1 stated she did not hear any alarms go off but reported if she was in a room assisting a resident, she could not hear anything that happened in the hallways. She also reported Resident #1 was wearing a t-shirt, pajama pants, and either socks, or socks and shoes.

An interview with Nurse #8 on 03/30/22 at 3:56 PM revealed he was working the 300/400 halls on 3rd shift 03/20/22 into 03/21/22. He stated Nurse Aide #12 called for him and let him know that Resident #1 was found outside the rear door. He stated he went to the 100 hall and found Resident #1 standing at the rear door. Nurse #8 reported he visually assessed Resident #1 and did not note any injuries but noted he was shivering. He also reported he did not document or report the incident to anyone, nor did he ask Resident #1 how he exited the building. Nurse #8 reported he

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have been added as a weekly task in TELS, a preventive maintenance tracking system. On March 30, 2022, the Director of Nursing/Nurse Manager began in-servicing all staff, to include agency staff, on the elopement policy to include immediate interventions for cognitively impaired Residents with exit seeking and wandering behaviors. Education included designated one-to-one staff on the assignment sheets. The Director of Nursing/Nurse Manager will ensure all staff, to include agency staff, who have not received this education by May 3, 2022, will not be allowed to work until education is completed. The Director of Nursing/Nurse Manager will ensure newly hired staff, to include agency staff, will receive education during facility orientation in person or via telephone during prior to working.
On March 31, 2022, the Director of Nursing/Nurse Manager began in-servicing Licensed staff and Certified Nursing Assistants, to include agency staff, on ensuring Residents care planned for falls, interventions are in place as indicated on the Kardex. The Director of Nursing/Nurse Manager will ensure all staff, to include agency staff, who have not received this education by April 30, 2022, will not be allowed to work until education is completed. The Director of Nursing/Nurse Manager will ensure newly hired staff, to include agency staff, will receive education during facility orientation in person or via telephone during prior to working.
Quality Assurance. The Director of

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F 689	Continued From page 34 was "baffled" because all the exit doors were locked and alarmed, and he had not heard any alarms go off during his shift. Nurse #8 did not mention putting 1:1 supervision into place during his interview. An interview with Nurse #10 on 03/30/22 revealed she worked on 3rd shift (11:00 PM - 7:00 AM) from 03/20/22 into the morning of 03/21/22. She reported she was scheduled to leave work at 6:00 AM on 03/21/22 and did her final walkthrough and checked on residents around 5:00 AM. She reported at that time, Resident #1 was observed resting quietly in his bed. During interviews with the Maintenance Director on 03/30/22 and 03/31/22 at 12:31 PM and 10:43 AM respectfully, he reported 3 exit doors in the facility were currently set up with wanderguard alarms. He reported he checked all the exit doors upon being told and found the rear door at the back of the 100 hall to be unlocked and the alarm disabled. He stated the other doors were locked with codes required to unlock them. He reported the doors also would unlock if you lifted a latch by each of the doors and pressed an emergency release button. He stated the latches were alarmed to sound while the latch was lifted but would stop if the latch was closed. He reported when he arrived at the building on 03/21/22 at 6:30 AM, he was informed by staff member, that Resident #1 had exited a rear door on the 100-hall of the facility. The Maintenance Director could not recall which staff member informed him. He reported he checked all the exit doors upon being told and found the rear door Resident #1 exited from to be unlocked and the alarm disabled. The Maintenance Director stated he reset the lock and ensured the alarm was	F 689	Nursing/Nurse Manager will monitor using a Quality Assurance tool. The monitoring will include a questionnaire of three staff on various shifts, to include agency, regarding the elopement policy, immediate intervention using the Safety Watch Log, staff delegation on assignment sheets, and Administration notification. Additional monitoring of wandering user defined assessments for completion and elopement books are up to date. The Director of Nursing/Nurse Manager will monitor using a Quality Assurance tool of Residents care planned for falls appropriate interventions are in place according to the Kardex. The QA monitoring will be conducted three times a week x 4 weeks, twice a week x 4 weeks, and then weekly x 4 weeks. The Administrator/Director of Nursing will monitor elopement drills and TELS tasks using a Quality Assurance tool weekly x 4 weeks, biweekly x 4 weeks, and then monthly x one month. The Administrator/Director of Nursing will report the results of the QA monitoring monthly to the Quality Assurance Performance Improvement (QAPI) committee for continued compliance and/or revision. Completion Date- 5/3/22	

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F 689	Continued From page 35 operating. He also reported the facility had security cameras inside and outside the facility and he was able to determine, after he reviewed security footage, that Resident #1 had exited the facility at 5:24 AM on 03/21/22 and returned to the same door at 6:15 AM. The Maintenance Director reported he could not determine where Resident #1 went after he left the building due to the setup of the cameras but was able to determine he exited in his wheelchair and returned on foot. He stated Resident #1's wheelchair was found in the lower parking lot in the back of the facility but could not remember who found it. The interview further revealed he informed the DON that Resident #1 had exited the building when she arrived that morning. The Maintenance Director then stated later that morning, while he was out of the facility on an errand, he received a telephone call from Unit Manager #1 stating that a door alarm was going off and needed to be reset. He stated when he returned to the facility, the alarm going off was the front wanderguard alarm, out of caution he also rechecked all exit doors. He stated when he rechecked the exit doors, he found the door Resident #1 had exited from earlier in the morning to again be unlocked and bypassed by the emergency button. He stated he in reviewed security footage again and was able to determine that Resident #1 had exited the building again in his wheelchair at unknown time and returned to the door around 10:00 AM still ambulating in his wheelchair. He reported this to the Director of Nursing (DON) after he reviewed the security footage. During an interview with Unit Manager #1 on 03/31/22 at 11:42 AM, she reported she was	F 689		

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informed by the DON that Resident #1 had eloped on the morning of 03/21/22. She reported she contacted the Maintenance Director later that morning because she could not reset the wander guard alarm on the main entrance door to the facility. She stated she did not know until recently that Resident #1 had gotten out of the facility a 2nd time.

An interview with Nurse #9 on 03/30/22 at 11:07 AM revealed she worked through an agency at the facility for 6-8 weeks. She stated when she arrived at 7:00 AM on 03/21/22 she was informed by an alert and oriented resident [Resident #2], that Resident #1 had eloped from the facility earlier that morning. She reported she was told that Resident #1 had exited the facility around 5:30 AM that morning and returned on his own sometime later. She reported since she was not informed of the incident during her shift report she immediately reported to the unit managers and the Director of Nursing (DON) who reported she was aware. Nurse #9 then stated she heard later in her shift from the DON that Resident #1 had attempted to bypass the door locks and elope again.

During an interview with a cognitively intact resident (Resident #2) on 03/30/22 at 11:32 AM he reported he exited his room at around 6:20 AM on 03/21/22 at noticed as commotion near the back door on his hall. He stated he overheard a staff member state, "I never heard anything; he must have bypassed the alarm". Resident #2 stated he observed Resident #1 being attended to near the door and was dressed in a long sleeve t-shirt, pants, and socks. Resident #2 reported he remembered thinking to himself it was dangerous for Resident #1 to be outside

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because it "was around freezing that morning".

Review of the recorded weather on 03/21/22 for Statesville, NC revealed at 5:52 AM, it was 40 degrees Fahrenheit with clear skies and winds at 5 miles per hour. Sunrise was at 7:26 AM. Source - weatherunderground.com and weather.com

Observation of the area where Resident #1 eloped revealed a long concrete pathway that ran the length of the side of the building. To the right of the door down the path, was another entry door into the facility. To the left of the door, the pathway continued to a group of 7-8 stairs that emptied into a lower parking lot. The entire area was surrounded by chain link fencing.

During an interview with NA #17 who worked on 1st shift on the 100-hall on 03/21/22 on 03/31/22 at 4:11 PM, she reported she did not hear any door alarms go off on her shift, nor did she know of any resident that had exited the facility that day.

NA #16 who was working on the 100-hall on 1st shift on 03/21/22 was interviewed on 03/31/22 at 2:39 PM. She reported she had heard a resident had exited the facility early on 03/21/22 but was not aware it happened again on her shift on 03/21/22. She reported she did not hear any door alarms go off on her hall during that shift.

During an interview with Nurse #4 on 03/31/22 at 11:02 AM, who worked on the back half of the 200-hall on 03/21/22 stated she only worked in the facility that one day. She reported she did not know anything about Resident #1 getting out of the facility and reported she did not hear any door

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alarms go off during her shift.

During interviews with the Director of Nursing (DON) on 03/30/22 at 6:00 PM, she reported she was made aware of Resident #1's elopement from the Maintenance Director when she arrived at the facility between 8:30 AM and 9:00 AM on 03/21/22. She made rounds with the Maintenance Director to ensure all the doors were locked and the alarms were working after being notified of the elopement. She stated later that morning she was told by an unknown staff member that the 3rd shift staff had implemented 1:1 supervision and she verified by "10:00 AM or 11:00 AM" there was a permanent 1:1 sitter with Resident #1. The DON reported she informed the physician who spoke with Resident #1 after the event and took him to the rear door where Resident #1 was able to demonstrate to the physician how he overrode the lock and was able to exit the building.

On 03/31/22 at 11:13 AM, the DON reported she did not remember the Maintenance Director telling her about the 2nd elopement but stated she may have been told and had forgotten. The DON reported she had to email the Administrator of the incident due to her being out of the country on vacation.

The Administrator was notified of immediate jeopardy on 03/31/22 at 3:45 PM.

On 04/01/21 at 9:51 AM, the facility provided the following Credible Allegation of Compliance:

Allegation of Compliance for F689

Identify those residents who have suffered, or

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F 689	Continued From page 39 likely to suffer, a serious adverse outcome as a result of the noncompliance: On 3/21/22 @ approximately 6:16am, Resident #1 was found unsupervised outside 100 Hall rear door knocking on the door for reentry. Based upon Licensed Nurse (LN) #1 interview, he was contacted by CNA #1 that she needed assistance because Resident # 1 was outside. LN#1 exited the 100-hall door and noted resident directly to the left of the door. He was standing and holding on to the wall of the building. LN #1 states he noted the resident's wheelchair approximately 25 additional feet to the left near the steps leading to the parking lot. Resident was returned to hallway by LN#1 with no identified injuries. An assessment was completed by LN#1. Resident had no apparent distress, no immediate care required. Resident verbally responded to staff appropriately. The Maintenance Director checked the doors when he arrived at the facility after being notified of the incident by LN#1. The 100-hall rear door Resident #1 exited from was found to be unlocked and the alarm disabled from someone - allegedly by Resident #1 by pressing the emergency bypass button located to the right of the door. LN#1 and Nurse Aide #1 both stated, they did not hear a door alarm sounding. The Director of Nursing was notified by the Maintenance Supervisor that resident disengaged door. The Director of Nursing and Maintenance Director reviewed the video footage for a camera located outside of 100 hall rear door. It was determined that the resident may have been outside approximately 45 minutes at approximate with Resident #1 exiting the 100-hall rear door at 5:24am. The Director of Nursing notified the Medical Director on 3/21/22. The physician spoke with Resident #1 and took him to the door and	F 689		

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Resident #1 was able to demonstrate to the physician how to hit the emergency unlock button to open the doors.

Based upon interview with the Maintenance Supervisor on 3/31/2022, there was a second unsupervised exit per the interview with the Maintenance Supervisor for Resident #1 on 3/21/2022. The Maintenance Director reported he was made aware by a telephone call later that morning from Unit Manager #1 that a door alarm was going off and the door was unlocked and needed to be reset. He stated he informed them how to reset the doors and was told when he returned to the facility by an unknown staff member that Resident #1 "might have" exited the building again. Per the video footage the Maintenance Director stated he was able to determine that Resident #1 returned to the same door "around 10AM". The Maintenance Director stated he reported the second elopement to the DON after reviewing the security camera footage.

On 3/21/22 @ approximately 10am, the Maintenance Director was informed to check the 100 Hall rear door. Resident #1 may have had another unsupervised exit. Maintenance Director checked the 100 Hall rear door, and it was noted to be secured and door alarm functioning properly.

An investigation began by the Director of Nursing on 3/21/22. Facility began seeking appropriate placement for resident in a secured unit with the consent of the Resident #1 responsible party. One to one observation was initiated on 3/21/2022 at approximately 10:30am and will continue until resident is transferred to a secure unit.

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

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

On 3/21/22, the Maintenance Director checked all exit doors to ensure they were locked and stop buttons were not deactivated.

An Elopement drill was completed on 3/31/22 by the Maintenance Director and Administrator. The Maintenance Director called Code Silver on overhead intercom at 7:18pm. A prop was utilized as a missing resident of the facility. The prop was placed in an empty resident room on an unoccupied hallway. After hearing the code silver page, facility staff proceeded to a centralized location (100 hall nurses' station) to get assignment of halls they should search. Facility staff began searching throughout the facility. Facility staff searched room to room and all other areas of the buildings (bathrooms, closets, laundry, shower rooms, under beds, utility rooms, offices, dining areas, kitchen, dayrooms, courtyards, and employee lounge areas. The prop was found by the facility Admissions Director at 7:21pm. The Maintenance Director paged an all clear on the overhead intercom. After the elopement drill, facility staff reported back to

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nurses' station for debriefing.

On 3/31/22 at 3pm, the facility contacted the door alarm company to audit all door alarms to ensure they were functioning appropriately. Also, to ensure alarm sound is adequate and loud enough to be heard even when resident room doors are closed. The Maintenance Director discussed with the door alarm company options as a backup secondary door alarm. A secondary alarm will be installed on each door. These alarms will require a staff member to manually reset the alarm before alarm will stop sounding. These secondary door alarms were ordered by the Maintenance Director on 3/31/2022. Tentative delivery date of 4/1/22. Facility staff will be educated on the secondary door alarms when received in the facility and installed by the Maintenance Director. As a temporary solution until the secondary door alarms are received in the facility and installed by the Maintenance Director, a coil spring was placed on each door alarm box by the Maintenance Director to mitigate the door closing automatically when released and alarm stopping prematurely.

Beginning 3/30/22 - 3/31/22, the Director of Nursing and Regional Director of Nursing completed elopement education with all current facility and agency staff, including nursing, dietary, maintenance and housekeeping and therapy and administrative staff. Education included a review of the facility elopement policy. As well, education emphasized the need to ensure effective supervision for cognitively impaired residents with wandering and exit seeking behaviors to prevent unsupervised exits from the facility. Resident care plan should be reviewed to determine resident specific

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interventions when wandering and/or exit seeking behaviors are identified. Any newly identified resident who exhibit exit seeking behaviors should be immediately assessed by the Licensed Nurse and an intervention implemented to mitigate any elopement attempts. All staff were educated on where the elopement binders are located. Elopement binders are located at each nurse's station and at the front desk. Additionally, emphasis was placed upon responding to door alarms timely when an alarm is heard sounding in the facility. Staff should check location of door alarm and observe for any residents. Staff should ensure all residents are accounted for and doors are secured appropriately. All staff were trained by the Maintenance Director on 3/31/22 on how to reset the door alarm(s). Any door malfunctions should be communicated to Maintenance Director or Administrator immediately. Nursing staff assignment for any resident who requires one to one will be noted on the staff assignment sheet. Staff were informed to review assignment sheet to determine if they are assigned to provide one to one supervision. The Director of Nursing will utilize a master employee list to track completion of education. This responsibility was communicated to the Director of Nursing by the Administrator on 3/31/22. Staff will not be allowed to work until education is completed. Education will also be included during orientation for newly hired staff.

On 3/31/22, the Director of Nursing, Unit Coordinator and Regional Director of Clinical Services completed an audit of residents at risk of exiting the facility unsupervised who are cognitively impaired and exhibit exit seeking and wandering behaviors to ensure appropriate supervision and safety. For residents identified at

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risk for elopement, an updated Wandering Risk Assessment was completed by the licensed nurse and care plans updated to ensure appropriate interventions implemented based on resident risk. The Unit Coordinator updated the Elopement Risk Binder to contain resident profiles, photographs, current Wandering Risk Assessment and care plan and placed binders at each nurse's station and front lobby.

Effective 3/31/22, Licensed Nurses were educated by the Director of Nursing, Unit Coordinator and/or Regional Director of Clinical Services on ensuring resident wandering assessments are completed accurately upon admission, quarterly and with changes in resident in resident condition. Any assigned wandering assessment will display (based upon date the assessment should be completed) in the user defined assessment portal in the facilities electronic medical record (EMR) system. Nurses were educated to review the user define assessment portal at the start of the shift to determine any wandering assessments due on their assigned shift for their assigned residents. An emphasis was placed on ensuring wandering assessments are thoroughly completed which includes contacting the resident's family to discuss past behavioral issues such as wandering/exit-seeking behaviors as well as a review of hospital records to determine if there is any history of exit-seeking behaviors. Unit Coordinator will monitor the user define assessment portal daily during clinical meeting to ensure wandering assessments are completed as scheduled.

Effective 3/31/22, all residents will be assessed for elopement risk by a Licensed Nurse upon

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admission, quarterly and with changes in resident condition.

Effective 3/31/22, residents identified at risk with exit seeking and wandering behaviors will have a care plan in place to ensure safety and profile, photo, Wandering Risk Assessment, and care plan will be placed in the Elopement Binder at the nurse station and front lobby. Residents with wanderguards will be monitored every shift for placement and every day for function by the licensed nurse.

Effective 3/31/22, the facility implemented a revised Safety Watch System to ensure continuous staff supervision for residents requiring 1:1 observation. The Administrator will ensure the 1:1 staff coverage is posted on the Safety Watch Schedule and assigned staff will utilize the Safety Watch Log to document coverage by signing and dating in and out times. Staff who are assigned 1:1 resident observation will utilize interventions per resident plan of care to distract, redirect and intervene as appropriate. Any concerns with following the plan of care will be reported to the Physician and Administrator and/or Director of Nursing immediately and additional interventions implemented as necessary.

Beginning 3/31/22, the Unit Coordinator, Director of Nursing and/or Regional Director of Clinical Services will provide education to facility and agency staff on the Safety Watch System and the expectation of providing continuous 1:1 supervision as assigned and the process to follow to ensure resident safety without any disruptions in continuous coverage. Education will include the process of utilizing the Safety Watch Log to

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document coverage by signing and dating in and out times. Staff who are assigned 1:1 resident observation will receive education on utilizing interventions per resident plan of care to distract, redirect and intervene as appropriate and reporting any concerns with following the plan of care and Safety Watch System to the Administrator and/or Director of Nursing immediately. The Director of Nursing will utilize a master employee list to track completion of education. This responsibility was communicated to the Director of Nursing by the Administrator on 3/31/22. Staff will not be allowed to work until education is completed. Education will also be included during orientation for newly hired staff.

Effective 3/31/22, staff assigned to provide 1:1 resident supervision will not leave resident unattended at any time. During staff breaks and during change of shift, an alternate staff member will provide supervision and document on-coming and off-going coverage by signature and date on the Safety Check Log. In the event of call-outs or late arrivals, the current staff will notify the Administrator or Director of Nursing immediately and will remain with resident to ensure continuous supervision until alternate staff coverage is obtained.

Effective 3/31/22, the facility will conduct elopement drills on all shifts monthly to ensure continued staff understanding of the facility process in the event of an elopement.

Effective 3/31/22, newly hired Maintenance Directors, Assistance Maintenance Director and Administrators will receive education by the Administrator or Director of Nursing on the wanderguard system, door security system and

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process for system malfunctions (as applicable). Education to include elopement policy and procedure, wanderguard system and doors and alarm safety checks weekly.

Effective 3/31/22, the facility will ensure proper functioning and monitoring of the wanderguard system and facility doors and alarm system. The Maintenance Director, Maintenance Assistant or Administrator will perform and document door and alarm safety checks at least weekly. This will be documented in the TELS system (electronic system used for maintenance tracking)

Effective 3/31/22, the facility Administrator or Director of Nursing will conduct weekly questionnaires with five (5) facility or agency staff to ensure proper understanding of providing effective supervision for cognitively impaired residents with wandering and exit seeking behaviors to prevent unsupervised exits from the facility.

Effective 3/31/22. the Administrator, Director of Nursing or Manager on Duty will review the Safety Watch Log to ensure continuous supervision is being provided and documented for residents assigned 1:1 observation. Monitoring will be conducted daily.

Effective 3/31/22, the Administrator or Regional Director of Operations and Director of Nursing will be ultimately responsible to ensure implementation of this immediate jeopardy removal for this alleged noncompliance.

Alleged date of IJ Removal: 4/1/22

On 04/01/22, the credible allegation of Immediate

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Jeopardy removal was validated by onsite verification. Elopement books were observed at each nurse's station that contained information and pictures of high risk residents. Multiple staff across all three shifts and from different disciplines were interviewed and verified they had received training and education on elopement, exit seeking behaviors, and facility alarms systems and response. The interviewed staff were able to describe facility policies on elopements and what steps they should take should they hear a door alarm go off. Observations were made of additional alarms placed at all exit doors that would alarm and continue to alarm if the doors were opened. Additional review of the facilities monitoring tools was completed with no concerns noted. The facility's date of Immediate Jeopardy removal of 04/01/22 was validated.

2. Resident #20 was admitted to the facility on 12/11/21 with diagnoses that included urinary tract infection and cerebral vascular accident.

The quarterly Minimum Data Set (MDS) assessment dated 03/18/22 revealed Resident #20's cognition was severely impaired and required extensive assistance with bed mobility and transfers. The MDS also indicated Resident #1 has had 2 falls without injury since admission.

A review of Resident #20's care plan updated on 03/21/22 indicated the Resident has had 3 recent falls without major injury related to poor balance. The goal that the Resident would resume usual activities without further incident would be attained by utilizing interventions that included keeping the bed in the lowest position.

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A review of Resident #20's medical record revealed she sustained a fall from the bed without major injury on 02/25/22, 02/28/22 and 03/21/22.

An observation of Resident #20 on 03/29/22 at 10:30 AM revealed the Resident was sleeping and lying on her side. The head of the bed was at an approximate 30 degree angle and the bed was approximately 3.5 feet off floor. The bed was not in the lowest position.

On 03/29/22 at 2:55 PM an observation of Resident #20 revealed she was lying on her back awake but nonverbal. The Resident's bed was in the highest position. There was no staff in the Resident's room. Nurse Aide, (NA) #2, who was not assigned to Resident #20, was asked to intervene with the Resident. The NA stated the Resident's bed should not be in left in high position because the Resident has had recent falls. The NA attempted to lower the bed using the bed remote control and the buttons on the foot board, but the bed could not be lowered. The NA checked the bed cords and looked behind the nightstand to ensure the bed was plugged into the outlet and it was. The bed could not be lowered. Nurse Aide #2 went to locate the Maintenance Supervisor (MS) who came to Resident #20's room and again checked the bed remote control, buttons on the foot board and ensured the bed was plugged into the wall outlet and could not lower the Resident's bed. The MS continued to assess the Resident's bed.

On 03/29/22 at 3:15 PM during an interview with Nurse Aide (NA) #2 the NA was asked how the nurse aides knew what interventions had been put in place for the residents' falls and the NA explained that the interventions for falls were on

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the residents' plan of care in the computer system and through word of mouth.

During an interview with Nurse Aide (NA) #4 on 03/30/22 at 12:20 PM the NA confirmed that she was assigned to Resident #20 on 03/29/22 from 7:00 AM to 3:00 PM. The NA explained that she went in to provide care for Resident #20 before shift change and the Resident's bed got stuck in high position and she could not get the bed to lower. The NA continued to explain that she left the Resident unattended and went to report the bed situation to the Maintenance Supervisor. The NA reported she did not know that Resident #20 has had recent falls from her bed, or she would not have left the Resident unattended with the bed in high position.

During an interview with the Maintenance Supervisor (MS) on 03/29/22 at 5:00 PM the MS explained that he unplugged the bed cord and plugged it back in and the bed started working.

An interview conducted with the Maintenance Supervisor on 03/30/22 at 4:15 PM revealed that he became aware of Resident #20's bed being stuck in high position was around 3:00 PM when Nurse Aide #2 informed him, and he immediately went to investigate the problem.

During an interview with the Unit Manager (UM) on 04/01/22 at 10:50 AM the UM explained that the nurse aides know what the residents' care plan interventions were by their point of care documentation in the computer. She continued to explain that all residents had the potential to fall from their beds so the NA #4 should never have left Resident #20 unattended with her bed in high position especially since she has had recent falls

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from her bed.

An interview was conducted with the Director of Nursing (DON) on 03/30/22 at 11:45 AM. The DON explained that she had been made aware of Resident #20's bed being left in high position on 03/29/22 and was told that a nurse aide went in the Resident's room to provide care for her but the bed got stuck in the high position and she could not lower the bed. The DON stated the nurse aide should not have left the Resident unattended with the bed in high position especially since the Resident has had recent falls from her bed.

An interview was conducted with the Regional Director of Clinical Services (RDCS) on 04/01/22 at 3:15 PM. The RDCS explained that the nurse aides had access to the care plan interventions on the point of care documentation in the computer and should follow the interventions. The RDCS indicated she could not explain why the Resident's bed would need to be in high position but regardless, Nurse Aide #4 should not have left the Resident unattended to report the problem to the Maintenance Supervisor.

F 693 SS=D — Tube Feeding Mgmt/Restore Eating Skills — F 693 — 5/3/22

CFR(s): 483.25(g)(4)(5)

§483.25(g)(4)-(5) Enteral Nutrition
(Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-

§483.25(g)(4) A resident who has been able to

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eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and

§483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.
This REQUIREMENT is not met as evidenced by:
Based on observations, record review, and staff interview the facility failed to ensure a bottle of tube feeding formula was dated when opened for use for 1 of 1 residents reviewed with a feeding tube (Resident #8).

The findings included:

Review of a nutritional product information for Jevity 1.5 from the manufacturer dated 06/29/01 read; hang no more than 24 hours once opened.

Resident #8 readmitted to the facility on 09/16/21 with diagnoses that included dysphagia and gastrostomy status.

Review of a physician order dated 02/07/22 read; Jevity 1.5 at 65 milliliters (ml) per hour continuous.

Review of the most recent quarterly Minimum Data Set (MDS) dated 03/06/22 indicated that Resident #8 was severely impaired for daily decision making and required total assistance of

F 693

Corrective actions for affected residents. On March 30, 2022, Nurse #2 discarded Resident #8 tube feeding bottle. A new bottle was hung and labeled with Resident #8's name, date, time and rate per hour. Resident discharged to the hospital on April 12, 2022.

Corrective action for potentially affected residents. On March 30, 2022, no other current Residents identified requiring enteral feeding.

Systemic Changes. On April 5, 2022, the Director of Nursing/Nurse Manager began in-servicing all current Licensed nursing staff and Certified Nursing Assistants, to include agency staff, on labeling enteral feeding with Residents name, date, time and rate per hour. The Director of Nursing/Nurse Manager will ensure all current Licensed nursing staff and Certified Nursing Assistants, to include agency staff, who have not received this

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F 693	Continued From page 53 one person for eating. The MDS further revealed that Resident #8 had a feeding tube and 51% or more of daily calories and 501 ml or more of daily fluid intake came from the feeding tube. An observation of Resident #8 was made on 03/29/22 at 11:03 AM. Resident #8 was resting in bed with the head of his bed elevated. He was observed to have a feeding tube that was connected to a pump and was infusing Jevity 1.5 at 65 ml per hour. The tube feeding label contained no name, no date, no time, and no rate of which the tube feeding formula should infuse. An observation and interview were conducted with Nurse #1 on 03/29/22 at 4:28 PM. Nurse #1 confirmed that she was taking care of Resident #8. She also confirmed that the tube feeding bottle was not labeled appropriately and stated that she had not hung a new bottle of feeding since coming on shift at 7:00 AM. Nurse #1 stated that the night shift nurse must have hung the new bottle and not labeled it appropriately. Nurse #1 stated that the tube feeding bottle should have the resident name, time, and date that it was hung and the name of the feeding and rate of administration with each new bottle that was hung. Review of the daily schedule for 03/28/22 indicated that Nurse #2 was taking care of Resident #8 from 7:00 PM to 7:00 AM. Nurse #2 was interviewed on 03/30/22 at 10:49 AM. Nurse #2 confirmed that she had worked night shift on 03/28/22 until 7:00 AM on 03/29/22. She stated that she was supposed to work on the unit where Resident #8 resided but that they had some extra nurses, so she was pulled to be a	F 693	education by May 3, 2022, will not be allowed to work until education is completed. The Director of Nursing/ will ensure newly hired staff, to include agency staff, will receive education during facility orientation in person or via telephone during prior to working. Quality Assurance. The Director of Nursing/Nurse Manager will monitor using a Quality Assurance tool. The monitoring will include Residents on enteral feeding bottles are labeled with their name, date, time and rate per hour. The QA monitoring will be conducted three times a week x 4 weeks, twice a week x 4 weeks, and then weekly x 4 weeks. The Director of Nursing/Nurse Manager will report the results of the QA monitoring monthly to the Quality Assurance Performance Improvement (QAPI) committee for continued compliance and/or revision. Completion Date- 5/3/22	

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"floater" and she believed that Nurse #3 was pulled to work the unit where Resident #8 resided. Nurse #2 stated that she had not hung a new bottle of tube feeding formula for Resident #8 during the night shift on 03/28/22.

Nurse #3 was interviewed on 03/30/22 at 10:56 AM. Nurse #3 confirmed that she had worked night shift on 03/28/22 until 7:00 AM on 03/29/22. Nurse #3 stated that she did not work the unit where Resident #8 resided. She stated that she was pulled to do assessments and she believed that Medication Aide (MA) #1 was pulled to work the unit where Resident #8 resided. Nurse #2 confirmed that she had not hung a new bottle of tube feeding formula for Resident #8 during the night shift on 03/28/22.

MA #1 was interviewed on 03/30/22 at 2:57 PM. MA #1 confirmed that she was working with Resident #8 on 03/28/22 on the night shift. She stated that she was not able to hang Resident #8's tube feeding formula that would have been the nurse that was overseeing her, but she could not recall which nurse that was. MA #1 stated that she does not recall Resident #8 tube feeding bottle running out on her shift or she would have notified the nurse.

Unit Manager (UM) #2 was interviewed on 04/01/22 at 11:56 AM. UM #2 stated that when the nurse hung a new bottle of tube feeding formula, they were expected to label the bottle with the resident name, date, time, and rate of administration on the label on the bottle. UM #2 stated that the tube feeding bottles were good for 24 hours once hung so it was very important to label them when the bottle was hung so that the bottle could be discarded appropriately.

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F 693	Continued From page 55 The Director of Nursing (DON) was unavailable for interview on 04/01/22. The Regional Director of Clinical Services (RDCS) was interviewed on 04/01/22. The RDCS stated she expected that the tube feeding bottle to be labeled with the resident's name, date, time, and rate of administration when the bottle was hung.	F 693		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews the facility failed to ensure that a broken piece of a resident's bipap mask (machine used to assist with breathing) was replaced to ensure a tight seal for proper administration for 1 of 1 resident reviewed with a bipap (Resident #13). The findings included: Resident #13 was admitted on 08/21/20 and most recently readmitted to the facility on 01/16/22 with diagnoses of obstructive sleep apnea, acute/chronic respiratory failure, and chronic	F 695	F695 Corrective actions for affected residents. On April 1, 2022, the Unit Coordinator replaced Resident #13 Bipap mask and assessed for proper seal. Corrective action for potentially affected residents. On April 18, 2022, the Director of Nursing/Nurse Manager began auditing current Residents requiring respiratory care with Bipap or Cpap. Three Residents were identified. The Director of Nursing/Nurse Manager assessed Residents masks for proper seal	5/3/22

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obstructive pulmonary disease.

Review of a physician order dated 08/03/21 read; bipap with nasal mask and humidification to be worn at night and as needed for naps.

Review of the Medicare 5-day Minimum Data Set (MDS) dated 02/02/22 indicated that Resident #13 was cognitively intact and required extensive assistance with activities of daily living. Oxygen was used during the assessment reference date.

Resident #13 was interviewed on 03/30/22 at 12:30 PM. Resident #13 stated that 3 weeks ago the metal clip on the head piece of her bipap machine had broken off. She stated Nurse #7 had reported the issue up the chain of management at the facility and was told that the piece had been ordered and "I still don't have the broken piece." Resident #13 stated that one of the nurses fed the strap through a loop on the head gear and we "tried to make it work" but it would not seal so she ended up having to take the bipap off. Resident #13 again confirmed that it had been 3 weeks since the piece broke, and she had been unable to wear the bipap as prescribed because she could not get and keep a good seal on the mask.

Nurse #7 was interviewed no 03/30/22 at 3:08 PM. Nurse #7 stated that either on 03/15/22 or 03/16/22 Resident #13 was taking her bipap mask off and when she did the metal clip on the head gear broke and went "flying" off. Nurse #7 stated that she searched Resident #13's bed and room from top to bottom and could not find the broken piece. Nurse #7 stated that on that night she tried to tie the strap to the mask to "make it work" and was able to keep it secure for a period

F 695

inspected for intactness. No issues identified.

Systemic Changes. On April 5, 2022, the Director of Nursing/Nurse Manager began in-servicing all current Licensed nursing staff and Certified Nursing Assistants, to include agency staff, on ensuring Residents with Bipap/Cpap masks are intact providing proper seal. If mask and/or equipment is broken, look in central supply room for replacement mask and/or equipment. If none found, contact the Physician for alternative orders. Communicate broken masks and/or equipment interventions to the Director of Nursing/Managers. The Director of Nursing/Nurse Manager will ensure all current Licensed nursing staff and Certified Nursing Assistants, to include agency staff, who have not received this education by May 3, 2022, will not be allowed to work until education is completed. The Director of Nursing/Nurse Manager will ensure newly hired staff, to include agency staff, will receive education during facility orientation in person or via telephone during prior to working.

Quality Assurance. The Director of Nursing/Nurse Manager will monitor using a Quality Assurance tool. The monitoring will include inspecting a sample of Residents masks utilizing Bipap/Cpap for intactness and proper seal. The QA monitoring will be conducted weekly x 4 weeks, biweekly x one month, and then monthly x one month. The Director of

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F 695	Continued From page 57 but then the mask began to leak air and the seal had been released and Resident #13 removed the bipap. Nurse #7 stated she could not recall who she reported to that day, but she stated she wrote the issue on the 24-hour report and told the Scheduling Coordinator when she made her rounds that morning and she stated she would report the issue in the morning meeting. Nurse #2 was interviewed on 03/31/22 at 3:26 PM. Nurse #2 confirmed that she worked the night shift at the facility and routinely cared for Resident #13. Nurse #2 stated that Resident #7 had not been wearing her bipap on the nights that she worked in the "last few weeks" due to a missing or broken piece that was reportedly ordered, and we were just waiting on that part to come in. Nurse #2 stated that Resident #13 continued to wear her oxygen at night and had no issue except one night she did ask for her as needed inhaler and that was given as requested. Nurse #2 stated she had checked her oxygen level and it was 94% at the time. Nurse #2 confirmed that the missing piece was a metal clip that connected the mask to the head gear and helped create a good seal. The Director of Nursing (DON) was interviewed on 03/31/22 at 4:02 PM. The DON stated that on 03/28/22 Resident #13's family had called and was upset that there was a missing piece to her bipap, and she was unable to wear it because she could not keep a good seal. The family stated that they had been waiting on a piece to come in and they could not understand why it was taking so long to get the piece. The DON stated she began asking the staff why they did not have a backup and then asked the Scheduling Coordinator if she had ordered the missing piece	F 695	Nursing/Nurse Manager will report the results of the QA monitoring monthly to the Quality Assurance Performance Improvement (QAPI) committee for continued compliance and/or revision. Completion Date- 5/3/22	

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F 695	Continued From page 58 and was told no. The DON stated that she ordered 2 masks knowing that the missing piece was a clip but that was at the time the only thing she had access too. The DON stated she was "hoping she could make the new mask work." The Scheduling Coordinator was interviewed on 03/31/22 at 4:36. The Scheduling Coordinator stated that the first that she knew about the issue was when the DON had asked her to order the missing clips on 03/30/22 and she had done so. The Scheduling Coordinator stated that she did not recall Nurse #7 reporting the issue to her but stated "she may have, and I may have forgotten about it." Unit Manager (UM) #1 was interviewed on 04/01/22 at 11:56 AM. UM #1 stated that she was unaware that Resident #13's bipap was missing a clip and believed that the issue was with the mask itself. She stated that the facility had some extra masks in the conference room, but she did not think they had the clips that Resident #13's bipap had but she would check. UM #1 stated that had she known that Resident #13 was only missing the clip it could have been ordered and replaced immediately after it broke. The Regional Director of Clinical Services (RDCS) was interviewed on 04/01/22 at 3:14 and stated she expected the staff to respond immediately when a bipap machine was broken. The issue should have been reported directly to the DON or supervisors so the piece could have been ordered and fixed for Resident #13.	F 695		
F 698 SS=D	Dialysis CFR(s): 483.25(l)	F 698		5/3/22

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F 698	Continued From page 59 §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility failed to obtain a physician's order for a resident to receive dialysis care and failed to facilitate and maintain consistent written communication from the dialysis center after each visit for 1 of 1 reviewed for dialysis services (Resident #21). Findings included: Resident #21 was re-admitted to the facility on 07/09/21 with diagnosis that included end staged renal disease and was dependent on renal dialysis. Review of Resident #21 active order summary printed on 4/1/22 revealed no physician order for dialysis. A review of Resident #21's scanned communication documents revealed the last documented communication provided from the dialysis center included labs performed in October 2021 and no further updates were a part of the medical record. A quarterly Minimum Data Set (MDS) dated 1/16/22 indicated Resident #21 was cognitively intact for decision making, required extensive assistance with activities of daily living (ADL), had no documented rejections of care, and received	F 698	Corrective actions for affected residents. On April 1, 2022, the Director of Nursing/Nurse Manager obtained Physician orders for Resident #21. The Director of Nursing/Nurse Manager called both dialysis centers informing the Supervisor of the need to complete the Dialysis Communication form for each Resident after dialysis. Corrective action for potentially affected residents. On April 18, 2022, the Director of Nursing/Nurse began audit currents Residents receiving dialysis for Physician orders. Four Residents were identified, Physician orders were in place. All current Residents have individual binders containing Dialysis Communication forms to accompany them and be completed by the dialysis center prior to return. Systemic Changes. On April 5, 2022, the Director of Nursing/Nurse Manager began in-servicing all current Licensed nursing staff and Certified Nursing Assistants, to include agency staff, on Physician orders needed for Residents receiving dialysis and Dialysis Communication forms. Education to licensed nurses included process of sending dialysis communication form with the resident to	

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F 698 Continued From page 60

dialysis services while a resident of the facility.

A dialysis plan of care dated 2/25/21 indicated Resident #21 received hemodialysis at the local dialysis center due to renal failure on Monday, Wednesday, and Friday and the had a shunt site in the left upper extremity.

MDS Nurse #1 was interviewed on 3/31/22 at 10:42 AM and reported that Resident #21 did regularly receive dialysis and could not explain why there was not a physician order for Resident #21 to receive dialysis. MDS Nurse #1 verified dialysis was coded correctly on the MDS dated 1/16/22.

An interview with Nurse #4 on 3/31/22 at 12:00 PM revealed she was familiar with Resident #21 and was aware he was a dialysis resident because his name was placed on the appointment for transport to the dialysis center; however, to her recollection, she had not received any documentation from the facility upon Resident #21's arrival from dialysis on dates she had worked.

An interview with the Director of Nursing on 3/31/22 at 12:30 PM revealed she was newly hired to the facility but was not able to locate an order for dialysis nor communication in the Electronic Medical Record (EMR) from the dialysis center since the scanned labs dated October 2021.

An interview with the Transportation Aide (TA)/Medical Records Coordinator on 3/31/22 at 1:00 PM revealed she was aware Resident #21 was under dialysis care and transported him to his appointments on Monday, Wednesday, and

F 698

dialysis and receiving, review/follow-up of dialysis note and providing to medical records for upload into resident electronic medical record (EMR). The Director of Nursing/Nurse Manager will ensure all current Licensed nursing staff and Certified Nursing Assistants, to include agency staff, who have not received this education by May 3, 2022, will not be allowed to work until education is completed. The Director of Nursing/Nurse Manager will ensure newly hired staff, to include agency staff, will receive education during facility orientation in person or via telephone during prior to working.

Quality Assurance. The Director of Nursing/Nurse Manager will monitor using a Quality Assurance tool. The monitoring will include a sample of Residents reviewed Physician orders and Dialysis Communication forms. The QA monitoring will be conducted three times a week x 4 weeks, twice a week x 4 weeks, and then weekly x 4 weeks. The Director of Nursing/Nurse Manager will report the results of the QA monitoring monthly to the Quality Assurance Performance Improvement (QAPI) committee for continued compliance and/or revision.

Completion Date- 5/3/22

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F 698	Continued From page 61	F 698		

Friday weekly. The TA stated he was unable to locate communication from the dialysis center since the labs scanned dated October 2021 and was under the impression dialysis had faxed communication to the facility since they did not send documentation back to the facility when he transported Resident #21 after his appointments. The TA also stated he could not locate the physician's order for dialysis, and he verified the order had not been inadvertently discontinued when the resident was previously discharged to the hospital and not re-entered. The TA stated the order was missed at his original admission and upon his readmission to the facility.

An interview with the Unit Manager #1 on 4/1/22 at 11:56 AM confirmed that there should be a physician order for dialysis. She stated that Resident #21 had received dialysis since his admission in July 2021. UM #1 also confirmed that she and the hall nurses were responsible for entering most of the orders in the facility and was just an oversight. She further state that the facility staff really did not do much with Resident #21's dialysis access site except they should definitely be monitoring for infection and bleeding.

An interview with the Regional Director of Clinical Services (RDCS) on 4/1/22 at 3:14 PM revealed Resident #21 should have an order to receive dialysis three times per week on Monday-Wednesday-Friday.

The Medical Doctor (MD) was interviewed on 4/1/21 at 6:00 PM. The MD stated that she generally did not write specific orders for dialysis, and she assumed the facility staff would just enter the order into the electronic system and she would sign off on it. She stated the important

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F 698	Continued From page 62 thing was that he was getting to/from dialysis 3 times a week. The MD further stated that the facility staff did not have to do anything to the access site except monitoring was required for bleeding and infection. The MD stated she was not aware Resident #21's EMR did not include any written communication between the facility and the dialysis center since October 2021.	F 698		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 761		5/3/22

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F 761

Continued From page 63

Based on observations and staff interview the facility failed to remove expired medications from 2 of 3 medication rooms (100 hall medication room and 200 hall medication room).

The findings included:

A. An observation of the 100-hall medication room along with Nurse #4 was made on 03/31/22 at 11:36 AM. The observation revealed a box of 30 prefilled 0.9% Sodium Chloride flushes that expired on 01/01/21 and an unopened bottle of Vitamin E 400 units that expired on 06/21 that contained 100 tablets. Both medications were in the cabinet and available for use by the staff.

Nurse #4 was interviewed on 03/31/22 at 11:41 AM. Nurse #4 explained she worked at the facility through an agency. She stated she had no idea who was responsible for checking the medication rooms nor was she aware of how to send the medication back to the pharmacy. Nurse #4 stated she would leave the expired medication on the counter and let the Unit Manager (UM) know to return them to the pharmacy.

B. An observation of 200 hall medication room along with UM #2 was made on 03/31/22 at 12:20 PM. The observation revealed the following expired medications that were in the refrigerator and/or cabinet and available for use:

-21 vials of Brovana (inhaled medication) 15 micrograms (mcg)/2 milliliters (ml) that expired on 01/22.
-1 bottle of Tubersol (used to check for exposure to tuberculosis) 5/0.1 ml that was opened on 01/20/22.
-1 bag of Ceftriaxone (antibiotic) 1 gram /100 ml

F 761

F761

Corrective actions for affected residents. On March 31, 2022, the Unit Managers discarded expired medication noted in the 100 hall and 200 hall medication rooms.
Corrective action for potentially affected residents. On April 1, 2022, the Unit Coordinators began auditing the three mediation rooms and five medication carts for expired medications. All expired medications were discarded. On April 20, 2022, the Pharmacy consultant conducted an audit of medication carts and medication rooms for expired medications. Expired medications noted were discarded. On April 18, 2022, the Central Supply coordinator began auditing the storage room for expired medications and/or supplements. This was completed by April 29, 2022.

Systemic Changes. On April 18, the Director of Nursing/Nurse Manager began in-servicing all current Licensed nursing staff and Certified Nursing Assistants, to include agency staff, on removing expired medications from the medication carts and placing them in a bin labeled “expired medications” located in the medication rooms awaiting return to the pharmacy. Education also included checking medications expiration date prior to opening, as well as, dating medications and supplements when opened. The Director of Nursing/Nurse Manager will ensure all current Licensed nursing staff and Certified Nursing Assistants, to include agency staff, who have not

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F 761

Continued From page 64
that expired 02/24/22.
-1 bag of Tigecycline (antibiotic) 100 milligram (mg)/100 ml that expired 12/18/21.
-1 unopened bottle of Aspirin 325 mg 100 tablets that expired 02/22.
-1 opened bottle of Sodium Bicarbonate 10.03 grain that expired 02/22.

UM #2 was interviewed on 03/31/22 at 12:38 PM. UM #2 stated that the Tubersol vial was only good for 30 days once opened and should have been discarded on or around 02/20/22. She further stated that she really was not sure who was responsible for checking medication rooms for expired medications. UM #2 explained that third shift was responsible for returning medications to the pharmacy but stated that all nursing staff who had access to the medication room should be checking the room for expired medications and if found should return them to the pharmacy.

UM #1 and UM #2 were interviewed on 04/01/22 at 11:56 AM. Both UM #1 and UM #2 confirmed that third shift was responsible for returning medications to the pharmacy and restocking the medications carts but could not say who was responsible for checking the medication rooms for expired medications. UM #1 stated that it was really all nursing staff responsibility to check the medication rooms and they should be checking them on all shifts and if any expired medications were found they should be returned to the pharmacy.

The Director of Nursing (DON) was unavailable for interview on 04/01/22.

The Regional Director of Clinical Services (RDCS) was interviewed on 04/01/22 at 3:14 PM

F 761

received this education by May 3, 2022, will not be allowed to work until education is completed. The Director of Nursing/Nurse Manager will ensure newly hired staff, to include agency staff, will receive education during facility orientation in person or via telephone during prior to working.

Quality Assurance. The Director of Nursing/Nurse Manager will monitor medication carts and medication rooms for expired medications using a Quality Assurance tool. The QA monitoring will be conducted weekly x 4 weeks, biweekly x one month, and then monthly x one month. In addition to the QA monitoring, the Pharmacy consultant will conduct monthly audits of the medication carts and medication rooms for expired medications. The Director of Nursing/Nurse Manager will report the results of the QA monitoring monthly to the Quality Assurance Performance Improvement (QAPI) committee for continued compliance and/or revision.

Completion Date- 5/3/22

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F 761	Continued From page 65 and stated that she expected all nursing staff to check the medication rooms each time they enter the room and if they discover expired medications they should be returned to the pharmacy.	F 761		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on a test tray, and Resident Council interviews and staff interviews the facility failed to serve food that was appetizing in temperature for 7 of 7 residents (Residents #12, #19, #22, #11, #10, #23, and #24) reviewed with food concerns. Findings included: Temperature monitoring of the lunch meal was conducted with Cook #2 on 03/29/22 at 11:33 PM. An observation of the lunch tray line was conducted 03/29/22 at 12:40 PM and a test tray was requested at this time. The meal consisted of fish nuggets, rice, and green beans. The test tray was plated on 03/29/22 at 12:42 PM, left the kitchen at 12:43 PM, and arrived on 100 hall at 12:44 PM. The test tray was sampled on 03/29/22 at 01:01	F 804	Corrective actions for affected residents. On March 29, 2022, Residents #12, #19, #22, #11, #10, #23, and #24 were offered new food trays or food to be warmed. On March 30, 2022, Dietary Manager order five cases of plate bottoms. Corrective action for potentially affected residents. On April 4, 2022, the Dietary Manager and Administrator completed a test tray to ensure meal was of nutritive value, appearance, palatable, and preferred temperature. No issues identified. Systemic Changes. On April 5, 2022, the Dietary Manager/Nurse Manager began in-servicing dietary staff on ensuring food is nutritive in value, appearance, palatable, and preferred temperature.	5/3/22

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F 804

Continued From page 66

PM after the last of the lunch trays on the hall had been served. The Regional Culinary Manager was present when the lid of the tray was removed. There was no visible steam observed when the lid was lifted. The fish nuggets, rice, and green beans were tasted by the Surveyor and Regional Culinary Manager, and all were barely warm.

An interview with the Regional Culinary Manager on 03/29/22 at 01:05 PM revealed he would have liked for the food to have been warmer. He stated the kitchen ran out of plate bases during the lunch meal service and that would have affected the food temperature.
A Resident Council meeting was conducted 03/29/22 at 2:40 PM. Resident #12, Resident #19, Resident #22, Resident #11, Resident #10, Resident #23, and Resident #24 attended the meeting. All residents reported their lunch meal was cold when they received it on 03/29/22.

An interview with the Dietary Manager on 03/31/22 at 08:55 AM revealed she had not yet received information regarding any food concerns that may have been mentioned in the last Resident Council meeting but she expected food to be served at an appetizing temperature. She explained the kitchen was running low on plate bottoms and that contributed to food not maintaining temperature. The Dietary Manager stated she ordered 5 cases of plate bottoms on 03/30/22. She stated another factor that contributed to food not maintaining an appetizing temperature was the fact that meal trays may not be distributed by nursing as soon as they reached the hall.

An interview with the Administrator on 03/31/22 at

F 804

Facility implemented communal dining.
The Dietary Manager/Nurse Manager will ensure all current dietary staff who have not received this education by May 3, 2022, will not be allowed to work until education is completed. The Regional Dietary Director/Dietary Manager will ensure newly hired staff will receive education during facility orientation in person or via telephone during prior to working.
On April 20, 2022, the Director of Nursing/Nurse Manager began in-servicing Licensed nursing staff and Certified Nursing Assistants, to include agency staff, on not taking breaks during Residents mealtime. The Director of Nursing/Nurse will ensure newly hired Licensed nursing staff and Certified Nursing Assistants, to include agency, will receive education during facility orientation in person or via telephone during prior to working. The Director of Nursing/Nurse Manager will ensure Licensed nursing staff who have not received this education by May 3, 2022, will not be allowed to work until education is completed.

Quality Assurance. The Regional Dietary Director/Dietary Manager/Nurse Manager will monitor using a Quality Assurance tool. The monitoring will include test trays and a random sample interview with Residents regarding the temperature of meals. Additional monitoring of staff not taking breaks during Resident mealtimes. The QA monitoring will be conducted three times a week x 4 weeks, twice a

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F 804	Continued From page 67 11:20 PM revealed she expected residents' food to be warm when they received it.	F 804	week x 4 weeks, and then weekly x 4 weeks. The Regional Dietary Director/Dietary Manager/Nurse Manager will report the results of the QA monitoring monthly to the Quality Assurance Performance Improvement (QAPI) committee for continued compliance and/or revision. Completion Date- 5/3/22	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to discard potentially hazardous food with obvious signs of spoilage available for resident use for 1 of 1 walk-in cooler; remove a	F 812	Corrective actions for affected residents. On March 29, 2022, the Regional Dietary Manager and Dietary Manager discarded items opened and not labeled and	5/3/22

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F 812

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black substance from all 4 walls of 1 of 1 walk-in cooler; keep the floor in 1 of 1 walk-in cooler clean and free of debris; keep the floor of 1 of 1 walk-in freezer free of debris; date an opened food item in 1 of 1 reach-in cooler; keep 1 of 1 reach-in cooler clean; date opened food items in 1 of 1 dry storage rooms; discard expired food items available for resident use from 1 of 1 dry storage rooms; ensure only resident food/drink was stored in 1 of 3 nourishment room freezers (nourishment room freezer for the isolation area); label, date, and store food in accordance with manufacturer's instructions in 1 of 3 nourishment rooms (nourishment room for the isolation area); and label and date food in 1 of 3 nourishment rooms (100 hall nourishment room).

Findings included:

1. An observation of the walk-in cooler on 03/29/22 at 10:29 AM revealed the following:

a. 6 one pound containers of strawberries with a green fuzzy substance on berries in each of the 6 containers
b. a black substance that was easily removable with a paper towel on all 4 walls
c. crumbs and dried bits of food on the floor
d. a dried black sticky substance in the middle of the floor

2. An observation of the walk-in freezer floor on 03/29/22 at 10:40 AM revealed scattered crumbs and dried bits of food on the floor.

3. An observation of the dry storage room on 03/29/22 at 11:03 AM revealed the following:

a. 3 opened bags of wheat cereal with an opened

F 812

showing signs of spoilage found in the walk-cooler, freezer, dry storage, and nourishment rooms. The walk-in cooler and freezer floors were cleaned. The walk-in cooler walls were cleaned.

Corrective action for potentially affected residents. On March 29, 2022, the Regional Dietary Manager and Dietary Manager began inspecting the walk-in cooler, freezer, dry storage, and nourishment rooms for items opened and not labeled, and showing signs of spoilage. Sanitation and Cleaning scheduled reviewed and updated.

Systemic Changes. On April 5, 2022, the Regional Dietary Manager/Dietary Manager began in-servicing all dietary staff on labeling food when opened, discarding food with signs of spoilage, discarding opened items not labeled, and cleaning schedule. The Regional Dietary Manager/Dietary Manager will ensure all current dietary staff who have not received this education by May 3, 2022, will not be allowed to work until education is completed. The Regional Dietary Manager/Dietary Manager will ensure newly hired staff will receive education during facility orientation in person or via telephone during prior to working.

Quality Assurance. The Regional Dietary Manager/Dietary Manager will monitor using a Quality Assurance tool. The monitoring will include auditing and inspecting the walk-in cooler, freezer, dry storage and nourishment rooms for

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ACCORDIUS HEALTH AT STATESVILLE	**520 VALLEY STREET STATESVILLE, NC 28677**

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F 812	Continued From page 69 date of 02/03/22 b. 1 opened and undated bag of crispy rice cereal c. 1 opened and undated bag of corn cereal d. 1 opened bag of crispy rice cereal with an opened date of 03/07/22 e. 2 packs of flour tortillas with an expiration date of 03/07/22 4. An observation of the reach-in cooler on 03/29/22 at 11:20 AM revealed the following: a. a large opened and undated container of grape jelly b. a large amount of dried white substance to the door and frame of the cooler that was easily removable with a paper towel During an interview with the Dietary Manager on 03/30/22 at 10:52 AM she confirmed the strawberries, opened bags of cereal, tortillas, and jelly were available for resident use. She stated the food truck made deliveries weekly and the last delivery was 03/24/22. The Dietary Manager explained the strawberries should have been inspected for signs of spoilage when staff was stocking them and notified her that the strawberries were not fresh so she could have returned the strawberries for credit with the food supplier. She stated when staff was restocking supplies in the dry storage room she expected them to rotate items by placing items that needed to be used first toward the front of the shelves while items with a longer expiration date could be placed farther back on the shelves. She stated if staff had rotated food correctly during the weekly restocking process they would have seen the tortillas were expired and would have seen not all opened bags of cereal were dated. The Dietary	F 812	resident only storage, open items are dated/labeled, no signs of spoilage/expiration, and floors/walls are free from debris. The QA monitoring will be conducted weekly x 12 weeks. The Regional Dietary Manager/Dietary Manager will report the results of the QA monitoring monthly to the Quality Assurance Performance Improvement (QAPI) committee for continued compliance and/or revision. Completion Date- 5/3/22	

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F 812	Continued From page 70	F 812		

Manager stated once bags of cereal were opened they were good for 7 days. She stated she also expected staff to check expiration dates at the time of use. She stated the expired tortillas and bags of cereal that had been open for longer than 7 days or had no open date should have been discarded. The Dietary Manager stated second shift was supposed to clean the walk-in cooler and walk-in freezer each evening and that included making sure the walls and floors were clean and free of debris. She stated the reach-in cooler was supposed to be cleaned weekly and as needed and there should not be a dried white substance to the reach-in cooler. The Dietary Manager stated all food was expected to be dated when it was placed in the reach-in cooler.

4. An observation of the nourishment room on the isolation hall on 03/31/22 at 10:50 AM revealed the following:

a. the door of the nourishment room freezer contained 4 unlabeled and undated frozen bags of breast milk
b. a cabinet in the nourishment room contained an opened and undated jar of pickles that stated "refrigerate after opening" on the lid of the pickles, an opened and unlabeled/undated 8 ounce container of mustard, and an opened and unlabeled/undated 32 ounce container of white vinegar

5. An observation of the 100 hall nourishment room on 03/31/22 at 11:05 AM revealed the following opened and unlabeled/undated items sitting on a counter:

a. a bag of brazil nuts
b. a box of vanilla wafers

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F 812	Continued From page 71 c. a box of wheat crackers d. a can of potato chips A follow-up interview with the Dietary Manager on 03/31/22 at 11:15 AM revealed the kitchen was responsible for checking nourishment rooms for unlabeled and undated food daily but often did not remove unlabeled or undated food items because they did not want staff to get mad at them. She stated if she checked the nourishment rooms and found unlabeled and undated items she discarded them. The Dietary Manager stated there was a refrigerator/freezer for employee use on the isolation hall and the breast milk should have been stored in the freezer for employee use and not in the nourishment room freezer. An interview with the Administrator on 03/31/22 at 11:20 AM revealed she expected food with obvious signs of spoilage to be discarded, expired food to be discarded, the kitchen to be clean, and all opened food to be dated and used or discarded within the appropriate time frame. She stated she expected the dietary staff to check nourishment rooms daily for expired food items or opened/unlabeled/undated food items and discard any items found. The Administrator stated there was an employee refrigerator/freezer on the isolation hall and any employee food or drink items should be stored there and not in nourishment rooms reserved for resident use.	F 812		
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	F 842		5/3/22

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F 842	Continued From page 72	F 842		

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-
(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.

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F 842	Continued From page 73 §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 services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and facility staff interviews, the facility failed to document an elopement of a cognitively impaired resident in the electronic medical record for 1 of 2 residents reviewed for supervision to prevent accidents (Resident #1). The findings included: Resident #1 was admitted to the facility on 01/24/22. An interview with Nurse #8 on 03/30/22 at 3:56 PM revealed he worked on 3rd shift (11:00 PM - 7:00 AM) from 03/20/22 into the morning of 03/21/22 and reported he brought Resident #1	F 842	Corrective actions for affected residents. On March 31, 2022, Resident #1 electronic medical record was updated. Corrective action for potentially affected residents. On March 29, 2022, The Director of Nursing/Nurse Manager reviewed all cognitively impaired Residents with exit seeking and wandering behavior to ensure risk assessment UDA were completed and progress note entered. Accurate and complete documentation noted. Systemic Changes. On April 5, 2022, the Director of Nursing/Nurse Manager began	

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F 842	Continued From page 74 back into the facility around 6:15 AM. He reported when Resident #1 returned, he visually assessed him and assisted him back to his room. Nurse #8 reported he did not make any formal documentation such as a progress note within Resident #1's electronic record because he was under the assumption that the nurse from Resident #1's hall (Nurse #10) would be responsible for documenting the exit. An interview with Nurse #10 on 03/30/22 revealed she worked on 3rd shift (11:00 PM - 7:00 AM) from 03/20/22 into the morning of 03/21/22 and was assigned to Resident #1. She reported she was scheduled to leave work at 6:00 AM on 03/21/22 and did her final walkthrough and checked on residents around 5:00 AM. She reported at that time, Resident #1 was observed resting quietly in his bed. During an interview with the Director of Nursing on 03/31/22 at 2:56 PM, she stated Nurse #1 should have written a progress noted on 3/21/22 about Resident #1's elopement since he was the one who assisted Resident #1. During an interview with the Administrator on 04/01/22, she reported she would have expected Nurse #1 to have written a progress note and placed it in Resident #1's electronic medical record following the elopement.	F 842	in-servicing all current Licensed nursing staff, to include agency staff, on documentation in Residents records to ensure completing incident reports. The Director of Nursing/Nurse Manager will ensure all current Licensed nursing staff to include agency staff, who have not received this education by May 3, 2022, will not be allowed to work until education is completed. The Director of Nursing/Nurse Manager will ensure newly hired staff, to include agency staff, will receive education during facility orientation in person or via telephone during prior to working. Quality Assurance. The Director of Nursing/Nurse Manager will monitor using a Quality Assurance tool. The monitoring will include a sample review of Residents electronic medical record for complete and accurate documentation to include risk events. The QA monitoring will be conducted weekly x 12 weeks. The Director of Nursing/Nurse Manager will report the results of the QA monitoring monthly to the Quality Assurance Performance Improvement (QAPI) committee for continued compliance and/or revision. Completion Date- 5/3/22	
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	F 867		5/3/22

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F 867

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assurance committee must:
(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;
This REQUIREMENT is not met as evidenced by:
Based on observations, record review, resident and staff interview the facility's Quality Assessment and Assurance (QAA) committee failed to ensure regulatory compliance with F689 and failed to maintain implemented procedures and monitor the intervention that the committee put into place on 03/25/22. This was for 2 repeat deficiencies in the area of Supervision to Prevent Accidents and Infection Control that were originally cited on 02/23/22 during a complaint investigation. The continued failure of the facility during the two federal surveys showed a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Program.

The findings included:

This citation is cross referred to:

F689: Based on observations, record review and resident and staff interviews, the facility staff failed to respond to a door alarm and prevent a resident with severe cognitive impairment from exiting the facility unsupervised (Resident #1). According to security footage Resident #1 exited the facility on 3/21/22 at 5:24 AM and was let back into the facility at 6:15 AM. Nurse #1 did not report the incident to anyone and did not put any interventions in place to prevent Resident #1 from exiting the facility. As a result, Resident #1 exited the facility unsupervised through the same door, at an undetermined time, later that same morning. The facility also failed to implement fall precautions and supervise a resident (Resident

F 867

Corrective actions. On April 21, 2022, the Quality Assurance Committee met and reviewed the purpose and function of the Quality Assurance Performance Improvement (QAPI) Committee as well as reviewed the on-going compliance issues regarding F689 and F880.

Corrective action for those potentially affected. On April 21, 2022, the Regional Nurse Consultant educated the Director of Nursing on the appropriate functioning on the QAPI Committee and the purpose of the Committee to include identify issues and correct repeat deficiencies related to F689 and F880. Education included identifying other areas of concern the Quality Improvement (QI) review process, for example: review of rounding tools, daily review of Point Click Care documentation, and observation during leadership rounds.

Systemic Changes. On April 21, 2022, the Administrator educated the QAPI committee members consisting of, the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Unit Support Nurses, Medical Records, Business Office Manager, Minimum Data Set (MDS) Nurse, Wound Nurse, Activities Director, Dietary Manager, Director of Rehabilitation, Social Worker, and Pharmacy consultant at (minimum

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#20) at risk for falls when the resident was left unattended in a bed raised to the highest position. This affected 2 of 3 residents reviewed for accidents.

During the complaint investigation completed on 02/23/22 the facility failed to investigate a fall and failed to update a smoking resident's smoking assessment when the resident began to smoke to determine if the resident was safe to smoke independently (Resident#3) and failed to secure a full oxygen tank that was left lying on a table in the facility chapel where residents and staff were noted to visit intermittently for 1 of 1 chapels observed.

F880: Based on observations, record review, and interviews the facility failed to implement infection prevention for hand hygiene by not removing gloves and performing hand hygiene after touching a face mask while plating food without serving utensils (Cook #1), failed to implement infection prevention for hand hygiene during a dressing change procedure for 1 of 2 residents (Resident #2) reviewed for wounds, and failed to don a gown and gloves for a resident on enhanced droplet precautions for 1 of 1 resident (Resident #9) reviewed for isolation precautions

During the complaint investigation completed on 02/23/22 the facility failed to implement their infection control policies and procedures and the Center for Disease Control and Prevention (CDC) guidance for COVID-19 when 2 of 2 Nurse Aides (NA #1 and NA#2) failed to wear eye protection during resident care encounters and did not doff gloves and perform hand hygiene before entering the hallway. The facility also failed to follow CDC recommended guidelines for resident's room

quarterly), on a weekly QA review of audit findings for compliance and/or revision needed. In addition to weekly QA meetings, the QAPI committee will continue to meet monthly.
Quality Assurance. The QAPI committee will continue to meet monthly to identify issues related to quality assessment and assurance activities as needed and will develop and implement appropriate plans of action for identified facility concerns. Corrective action has been taken for the identified concerns related to repeat deficiencies.

The monitoring procedure to ensure the plan of correction is effective and specific cited deficiencies remains corrected and/or in compliance with the regulatory requirements is oversight by corporate staff. Corporate oversight will validate the facility’s progress, review corrective actions and dates of completion. The Administrator will be responsible for ensuring QAPI committee concerns are addressed through further training or other interventions

Completion Date- 5/3/22

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F 867	Continued From page 77 labeled Enhanced Droplet Control Precautions (ECDP) when 2 staff members (Housekeeper #2 and Nurse #10) and failed to don/doff required personal protective equipment and remove gloves and perform hand hygiene. In addition, Housekeeper #1 did not wear her mask to cover both her mouth and nose and did not doff gloves and perform hand hygiene. These observations occurred for 5 of 5 staff members reviewed for infection control practices. The Administrator was interviewed on 04/01/22 at 6:19 PM. The Administrator stated that the facility's quality assurance team met monthly and reviewed the current citations and the audits that went with those citations. She stated she had divided the audits up among the management team but she along the Director of Nursing reviewed them and made sure they were done, and no issues were identified. The Administrator stated she was off work for 9 days and had not had time to review the recent audits but stated "it is not the system it is the people working the systems."	F 867		
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	F 880		5/3/22

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F 880	Continued From page 78 and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, 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	F 880		

F 880

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by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observations, record review, and interviews the facility failed to implement infection prevention for hand hygiene by not removing gloves and performing hand hygiene after touching a face mask while plating food without serving utensils (Cook #1), failed to implement infection prevention for hand hygiene during a dressing change procedure for 1 of 2 residents (Resident #2) reviewed for wounds, and failed to don a gown and gloves for a resident on enhanced droplet precautions for 1 of 1 resident (Resident #9) reviewed for isolation precautions.

Findings included:

Review of the facility's policy titled "Handwashing Guidelines-Dietary Employees" last revised 10/28/20 read in part:

A. Dietary employees shall keep their hands and exposed portions of their arms clean.

B. Frequency of Handwashing:

F 880

Corrective actions. On March 29, the Dietary Manager educated Cook #1 on infection control regarding hand hygiene. On April 1, 2022, The Regional Clinical Director educated the Wound Nurse on infection control regarding wound care. On April 1, 2022, the Rehabilitation Director educated the Occupational Therapist on the COVID-19 policy regarding appropriate PPE for residents requiring enhanced droplet precautions and hand hygiene.

Corrective action for those potentially affected. On March 29, 2022, the Dietary Manager began educating all dietary staff on hand hygiene. On April 1, 2022, the Unit Support Nurses conducted an audit of currents on enhanced precautions. Six residents were noted and appropriate signage on their door. On April 1, 2022, The Administrator/Director of Nursing/Nurse Manag begin educating all

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Dietary employees shall clean their hands in the following situations:

-After hands have touched bare human body parts other than clean hands (such as face, nose, hair, etc.)

1. Observations of Cook #1 on 03/29/22 revealed she adjusted her face mask with gloved hands at 11:56 PM, 12:10 PM, 12:12 PM, 12:18 PM, 12:21 PM, and 12:27 PM while plating food. Cook #1 used her gloved hands to pick up baked fish, hamburgers, hot dogs, lettuce, tomatoes, and sliced cheese instead of using serving tongs or other serving utensil while plating those food items. Cook #1 did not remove her gloves, perform hand hygiene, or apply a fresh pair of gloves after adjusting her mask and before continuing to plate food or touch food directly with her gloved hands.

An interview with Cook #1 on 03/30/22 at 09:57 AM revealed she plated food for the lunch meal on 03/29/22. She stated she had been trained to wash her hands and put on a fresh pair of gloves if she touched her hair or mask. Cook #1 stated she did not realize she adjusted her mask while plating food or she would have removed her gloves, washed her hands, and put on a clean pair of gloves. She stated she had serving utensils available when she was plating food on 03/29/22 and she was supposed to use them to plate food, but it was quicker for her to pick up the food with her hands.

An interview with the Dietary Manager on 03/30/22 at 10:52 AM revealed staff had been trained if they touched their mask while plating

F 880

staff, to include agency and vendors, regarding appropriate PPE for Residents on enhanced droplet precautions. The Director of Nursing/Nurse Manager educated Licensed Staff, to include agency, on hand hygiene during wound care.

Systemic Changes. On April 5, 2022, the Director of Nursing/Nurse Manager began in-servicing all current Licensed nursing staff, to include agency staff, on hand hygiene during wound care. The Administrator/Director of Nursing/Nurse Manager will ensure all staff, to include agency and vendors, be educated on infection control regarding appropriate PPE for Residents on enhanced droplet precautions. The Administrator/Director of Nursing/Nurse Manager will ensure newly hired staff, to include agency staff and vendors, will receive education during facility orientation in person or via telephone prior to working. Any staff who have not received this education by May 3, 2022, will not be allowed to work until education is completed.

Quality Assurance. The Administrator/Director of Nursing/Nurse Manager will monitor using a Quality Assurance tool. The monitoring will include observation of dietary staff utilizing hand hygiene during food preparation. Monitoring of Residents requiring enhanced precautions ensuring physician orders in place, appropriate signage in place, observations of staff utilizing the appropriate PPE. The QA monitoring will

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 81 food they should remove their gloves, wash their hands, and put on new gloves before continuing to plate food. She stated she expected food to be plated using the appropriate utensil for the food being served. An interview with the Administrator on 03/31/22 at 11:20 AM revealed she expected staff to remove their gloves, wash their hands, and apply a clean pair of gloves after touching their mask and before continuing to plate food. She stated she expected staff to use appropriate utensils when plating food. 2. A review of a policy titled "Clean Dressing Change" dated 10/28/21 revealed: It is the policy of this facility to provide wound care in a manner to decrease the potential for infection and/or cross-contamination. 7. Wash hands and put on clean gloves. 9. Loosen the tape and remove the existing dressing. 10. Remove gloves pulling inside out over the dressing and discard into appropriate receptacle. 11. Wash hands and put on clean gloves. Resident #2 was diagnosed with a stage IV pressure ulcer to the right buttock on 01/27/22. On 04/01/22 at 10:30 AM an observation of a stage IV pressure ulcer treatment provided by the Wound Care Nurse (WCN) went as follows: the WCN entered Resident #3's room with the ordered treatment supplies in her gloved hands and placed the treatment supplies on the Resident's over bed table. The Nurse then picked up the Resident's urinary catheter off the floor and attempted to hang the catheter bag on the bed frame but the catheter bag was disconnected from the hook that attached the bag to the bed	F 880	be conducted weekly x 12 weeks. The Administrator/Director of Nursing/Nurse Manager will report the results of the QA monitoring monthly to the Quality Assurance Performance Improvement (QAPI) committee for continued compliance and/or revision. Completion Date-5/3/22 (see DPOC attachments)	

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frame. The WCN used both hands to reattach the hook to the catheter bag before she hung the catheter bag on the bed frame. The WCN then assisted the Resident to his left side and pulled his pajama pants down to expose the old dressing on his right buttock. The WCN removed the old dressing with her left hand then picked up a premoistened gauze of wound cleanser from a plastic cup with her right hand and cleansed the pressure ulcer. She then picked up a medicine cup that contained Santyl ointment (a debriding agent) and a q-tip with her right hand and put the cup in her left hand and used the q-tip to apply the ointment to the pressure ulcer. The WCN then picked up a clean gauze and packed the pressure ulcer. The Nurse then peeled the paper edges from a foam dressing and applied the dressing to the pressure ulcer. The Nurse threw the used treatment supplies away in the trash and replaced the Resident's personal items on the over bed table and repositioned the table over the Resident's bed before she removed her gloves and washed her hands.

An interview was conducted with the Wound Care Nurse (WCN) on 04/01/22 at 10:39 AM. The Nurse was asked when she should change her gloves during a pressure ulcer dressing change and the Nurse replied that she should change her gloves and sanitize her hands after removing the old dressing and before applying the new dressing but stated she thought she only used the left hand to remove the old dressing. When asked how she was trained to preform dressing changes the WCN replied she had only been at the facility for two weeks and the way she performed the dressing change was the way she had always performed the dressing changes. The Nurse was asked about touching the Resident's

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catheter bag before she performed the dressing change and she replied that she should have removed her gloves and washed her hands before she continued with the treatment but stated she just didn't think about it since situations like that didn't happen often.

During an interview with the Unit Manager (UM) on 04/01/22 at 10:50 AM she explained that the Wound Care Nurse (WCN) should have changed her gloves and sanitized her hands after she picked the Resident's urinary catheter off the floor and hung it on the bed frame. The UM continued to explain that the WCN should have removed her gloves and sanitized her hands after she removed the old dressing and after she completed the dressing change procedure.

The Director of Nursing was unavailable for interview.

An interview was conducted with the Regional Director of Clinical Services (RDCS) on 04/01/22 at 4:10 PM. The RDCS stated that it was her expectation that the Wound Care Nurse remove her gloves and use hand sanitizer between removing the old dressing and applying the new dressing and after the treatment was completed.

3. Resident #9 was admitted on 03/15/22.

Review of a physician order dated 03/16/22 read, maintain resident on enhanced droplet precautions for 14 days.

Review of admission Minimum Data Set (MDS) dated 03/18/22 indicated that Resident #9 was moderately impaired for daily decision making

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and required limited assistance with activities of daily living. No isolation was noted during the assessment reference period.

An observation of Resident #9's door was made on 03/29/22 at 12:06 PM. There was a sign posted on the door frame that read enhanced droplet precautions and indicated that a gown and gloves were to be applied when entering the room along with a mask and eye protection. The door to Resident #9's room was open, and the Occupational Therapist (OT) was observed in Resident #9's room donned in only a N95 mask and goggles, he had no gown or gloves in place. The OT was observed touching the environment in Resident #9's room including the bed, wheelchair and bedside table.

The OT was interviewed on 03/29/22 at 3:32 PM. The OT confirmed that he was in Resident #9's room earlier that day and did not have a gown or gloves on because he "was just checking in on him." The OT stated that some of the rooms had isolation signs on the door and "we don't have to apply personal protective equipment for all the rooms" but with Resident #9 I generally apply the gown and gloves. The OT stated that since he was "just checking" on Resident #9 he did not think he needed to apply the gown and gloves.

Unit Manager (UM) #1 was interviewed on 04/01/22 at 11:56 AM. UM #1 stated that all staff should be following the sign on the door for applying personal protective equipment, even if just checking on the resident. If the sign says don a gown and gloves, then the staff should don a gown and gloves. UM #1 stated all staff were wearing N95 mask and goggles but should applying the gown and gloves when entering a

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F 880	Continued From page 85 room that was under enhanced droplet precautions. UM #1 stated that Resident #9 was under 14-day isolation because he was not vaccinated against COVID-19. The Director of Nursing (DON) was unavailable for interview on 04/01/22. The Regional Director of Clinical Services (RDCS) was interviewed on 04/01/22 at 3:14 PM. The RDCS stated she expected the staff to follow the sign on the door for applying personal protective equipment when entering a room.	F 880		
F 887 SS=F	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those	F 887		5/3/22

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additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses;
(v) The resident or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision;
Note: States that are not subject to the Interim Final Rule - 6 [CMS-3415-IFC], must comply with requirements of 483.80(d)(3)(v) that apply to staff under IFC-5 [CMS-3414-IFC]
and
(vi) The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and
(B) Each dose of COVID-19 vaccine administered to the resident; or
(C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and
(vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following:
(A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine;
(B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and
(C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN).
This REQUIREMENT is not met as evidenced by:

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Based on record review, resident and staff interview, the facility failed to implement an effective process for tracking and documenting the COVID-19 vaccination statuses in the electronic medical record (EMR) for 5 of 5 residents (Resident #14, Resident #15, Resident #16, Resident #17, and Resident #18), failed to include education regarding the COVID-19 vaccination in the EMR for 6 of 6 residents (Resident #12, Resident #14, Resident #15, Resident #16, Resident #17, and Resident #18) , failed to offer the COVID-19 vaccination booster to 3 of 6 residents reviewed for resident vaccinations status (Resident #Resident #12, Resident #14, and Resident #16) and administered a COVID-19 booster vaccines without a physician's order for 1 of 1 residents.

Findings included:

A review of the facility's policy titled "COVID-19 Vaccination- Resident" revised 2/28/22 read in part: It is the policy of this facility to minimize the risk of acquiring, transmitting, and experiencing complications from COVID-19 by educating and offering our residents and staff the COVID-19 vaccine. 1. If is the policy of the facility, in collaboration with the medical director, to have an immunization program against COVID-19 disease in accordance with national standards of practice. 3. The mRNA vaccines are to be given as a two-dose regimen within 21 days between doses for the Pfizer-BioNTech and 28 days between the Moderna doses and the Janssen (Johnson & Johnson) dose is a single dose regimen. 4/5 A booster dose of the mRNA vaccine by Pfizer-BioNTech and Moderna is recommended at least 5 months after the primary dose and 6. A booster dose of the viral vector vaccine Janssen

F 887

Current Residents affected. Currents Residents who are unvaccinated and/or booster eligible will be offered a COVID-19 vaccination through the facility vaccination clinic. Residents who decline will sign a declination form and educated on risks versus benefits of the COVID-19 vaccination. Declination forms will be scanned and updated in their electronic medical record.

Corrective action for potentially affected residents. On April 18, the Director of Nursing/Nurse Manager began auditing current Residents to ensure Physician orders written for the COVID-19 vaccination, (booster) if eligible, consent/declination forms uploaded in EMR, and refusals for tracking to offer at each clinic. Facility conducted a vaccination clinic on April 20, 2022, in which 14 Residents received their vaccinations. Residents who previously refused and booster eligible will be offered the vaccination. Consent/declination forms educating on risks versus benefits will be completed and uploaded to Resident�s electronic medical records. A Residents vaccination log of unvaccinated and booster eligibility will be created for tracking.

Systemic Changes. On April 5, 2022, the Director of Nursing/Nurse Manager began in-servicing all current Licensed nursing staff/Medical Records Coordinator, to include agency staff, on offering and signing up unvaccinated/booster eligible Residents for the COVID-19 vaccine.

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(Johnson & Johnson) is recommended at least 2 months after completion of the single-dose regimen. 14. Following assessment for potential medical contraindications, COVID-19 vaccinations for residents may be administered in accordance with physician-approved "standing orders." 16. Prior to offering the COVID-19 vaccine, residents, or the resident's representative, will be educated regarding the risks, benefits, and potential side effects associated with the vaccine in a form and manner that can be accessed and understood. 22.The resident's medical record will include documentation of the following: a. education to the resident or resident representative regarding risks, benefits, and potential side effects of the COVID-19 vaccine. B. each dose of the vaccine administered to the resident, c. if the resident did not receive the COVID-19 vaccine due to medical contraindication or refusal.

A review on 3/31/22 of the National Healthcare Safety Network (NHSN) data week ending 03/26/22 revealed the following staff vaccination status:

Recent Percentage of Residents' who are Fully or Partially Vaccinated = 54%
Recent Percentage of Fully Vaccinated Residents Who Received a Booster Dose = 0%

a..Resident #14 was admitted to the facility on 10/26/21.

A quarterly Minimum Data Set (MDS) fated 3/15/22 indicated Resident #14 was cognitively intact for decision making.

A review of the immunization record for Resident

F 887

Signed consent/declination forms should be uploaded to the Residents electronic medical records. The Director of Nursing and Nurse Manager will maintain a vaccination tracking log and update with changes to vaccination status. Vaccine status will be verified upon admission and administered as elected, including boosters when eligible per CDC vaccine scheduling guidelines. Vaccine schedules will be monitored weekly by the Director of Nursing/Nurse Manager to adhere to schedule. The Director of Nursing/Nurse Manager will ensure all current Licensed nursing staff/Medical Records Coordinator, to include agency staff, who have not received this education by May 3, 2022, will not be allowed to work until education is completed. The Director of Nursing/Nurse Manager will ensure newly hired staff, to include agency staff, will receive education during facility orientation in person or via telephone during prior to working.

Quality Assurance. The Director of Nursing/Manager will monitor using a Quality Assurance tool. The monitoring will include a sample review of five (5) surrent residents electronic medical record for vaccination consent/declination forms with risks versus benefits and Physician Orders for vaccine administration, The QA monitoring will be conducted weekly x 12 weeks. The Director of Nursing/Nurse Manager will report the results of the QA monitoring monthly to the Quality Assurance Performance Improvement (QAPI)

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F 887	Continued From page 89 #14 indicated he had not received any COVID-19 vaccinations. A review of Resident #14's immunization consent form electronically signed on 10/29/21 indicated he had received the Moderna vaccine. An interview with Resident #14 on 4/1/22 at 12:18 PM revealed he had been fully vaccinated at a local nursing facility but had not been offered a COVID-19 booster since he was admitted to the facility. b.Resident #15 was admitted to the facility on 2/23/22. An admission MDS dated 3/1/22 indicated Resident #15 was cognitively intact for decision making. A review of the immunization record for Resident #15 indicated he had not received any COVID-19 vaccinations. A review of Resident #15's immunization consent form electronically signed on 2/23/22 indicated he had received the COVID-19 vaccine but did not provide further details of which manufacturer. An interview with Resident #15 on 4/1/22 at 12:20 PM revealed he had been fully vaccinated and received a booster vaccine at a local nursing facility prior to admission. c. Resident #16 was admitted to the facility on 10/21/22. A discharge-return anticipated MDS dated 3/7/22 indicated Resident #16 was cognitively intact for	F 887	committee for continued compliance and/or revision. Completion Date- 5/3/22	

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decision making
.
A review of the immunization record for Resident #16 indicated he had not received any COVID-19 vaccinations.

A review of Resident #16's immunization consent form electronically signed on 10/21/21 indicated he had received the COVID-19 vaccine by Janseen but authorized permission to receive additional booster doses.

An interview with Resident #16 on 4/1/22 at 12:25 PM revealed he had been fully vaccinated at another nursing facility prior to admission but had not been offered a COVID-19 booster since admission to the facility.

d. Resident #17 was admitted to the facility on 8/28/21.

A quarterly MDS dated 12/31/21 indicated Resident #17 was cognitively intact for decision making.

A review of the immunization record for Resident #17 indicated he had received Step #1 of the COVID-19 vaccine; however, it did not indicate he received the Janseen single dose vaccination. The vaccination documentation did not indicate Resident #17 had received a second dose or a COVID-19 booster vaccine.

A review of Resident #17's immunization consent form electronically signed was unable to be provided by the facility during the survey.

An interview with Resident #17 on 4/1/22 at 12:35 PM revealed he had received the single dose of

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the Janseen, and he indicated he had received a COVID-19 vaccine booster in the facility in December 2021. Resident #17 stated on the day he received the booster; he was rolling his wheelchair down the hallway past the conference room where staff were being administered COVID-19 boosters when a staff member stated there was 2 booster doses remaining that they did not want to waste them, and they offered and administered it to him on that day. Resident #17 provided a copy of his vaccination card which indicated he had received the Janseen single dose vaccine on 06/29/21 and a Janseen booster on 12/3/21.

e.Resident #18 was admitted to the facility on 10/8/21.

A quarterly MDS dated 1/9/22 indicated Resident #18 was cognitively intact for decision making.

A review of the immunization record for Resident #18 indicated he had not received any COVID-19 vaccinations.

A review of Resident #18's immunization consent form electronically signed was undated and was blank. It did not indicate whether he had received any COVID-19 vaccinations nor if he consented or refused the COVID-19 vaccine.

An interview with Resident #18 on 4/1/22 at 12:40 PM indicated he had not received any COVID-19 vaccinations or boosters and did not consent to have a vaccine.

An interview with the Unit Manager on 4/1/22 at 11:56 AM revealed she was aware there was a lack of process in place to track resident

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immunizations. She indicated she had started making a list the prior week to start determining who had been vaccinated and who had not but hadn't completed a list to determine what vaccinations needed to be offered, education provided or administered.

An interview with the Regional Director of Clinical Services (RDCS) on 4/1/22 at 3:14 PM revealed she would expect all residents to be offered the COVID-19 vaccine, a consent to be obtained, education to be provided, and if consent obtained, a physician's order to be obtained, and the immunization to be administered and documented in the medical record timely. The RDCS stated she was not aware the immunization information was not being documented accurately in the medical record and was not aware there was no tracking system in place for the administration of the COVID-19 vaccinations. She was also unaware Resident #17 had received a COVID-19 vaccination booster that was designated to be administered to facility staff nor that it was not documented in his medical record.

An interview with the Medical Director (MD) on 4/1/22 at 6:00 PM revealed she was not aware the COVID-19 vaccination had not been added to the facility's standing orders and therefore had not written individual orders for each resident to have the vaccine administered when a consent was obtained. She indicated a physician's order was needed to administer a vaccination and it should be documented in the medical record following administration.

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F 888 SS=F	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x)	F 888		5/3/22

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	345128	A. BUILDING ______ B. WING ______	C 04/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT STATESVILLE	520 VALLEY STREET STATESVILLE, NC 28677

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F 888		F 888		

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§483.80(i)
COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine.

§483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents:
(i) Facility employees;
(ii) Licensed practitioners;
(iii) Students, trainees, and volunteers; and
(iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement.

§483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff:
(i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and
(ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section.

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

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F 888	Continued From page 95 documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to	F 888		

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F 888	Continued From page 96 the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to implement an effective process for tracking the COVID-19 vaccination status for 49 of 105 (47%) staff working in the facility who were reviewed for COVID-19 Vaccination Status. The facility was not currently in outbreak status. Findings included: A review of the facility document titled "Employee COVID-19 Vaccination Mandate Policy" revised 12/28/21 read in part: 1. The facility will ensure that all eligible employees are fully vaccinated against COVID-19, unless religious or medical exemptions are granted. 2.All employees include the following: Facility employees, licensed practitioners, students/trainees/and volunteers, and individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement. 14. The facility will track and securely document the vaccination status of each staff member (current and as new employees are onboarded). A review on 3/31/22 of the National Healthcare Safety Network (NHSN) data week ending 03/26/22 revealed the following staff vaccination status: Recent Percentage of Staff who are Fully or Partially Vaccinated = 100%	F 888	F888 Corrective actions. Facility failed to implement an effective process for tracking the COVID-19 vaccination status of employees. Corrective action for those potentially affected. On April 18, the Director of Nursing/Business Office Manager/Nurse Manager began auditing the documented COVID-19 vaccination status of employees, to include agency and vendors, who provide care, treatment or other services for the facility and/or Residents. One facility Employee approved medical exemption in place. Systemic Changes. On April 5, 2022, the Administrator/Director of Nursing began in-servicing department managers, on obtaining documented COVID-19 vaccination status of agency staff. Additional education includes obtaining documented COVID-19 vaccination status of vendors and/or individuals who provide care, treatment, or other services prior to services being rendered. Direct care employees' vaccination status will be entered in hosted time, our time management system, for tracking purposes. The COVID-19 vaccination status of vendors will be obtained at	

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Recent Percentage of Staff who are Fully Vaccinated = 100%

A review of the COVID-19 Staff Vaccination Status for Provider indicated 56 staff member names and indicated all staff were fully vaccinated and 7 staff members had received the COVID-19 vaccination booster.

A review of all facility's departmental schedules for 3/26/22 to 3/31/22 revealed 105 staff members worked in the facility to provide services.

A comparison review between the schedules and the COVID-19 Staff Vaccination Status document revealed 49 of the 105 staff members who worked were not included on the vaccination log provided by the facility.

An interview with Activities Assistant on 03/30/22 at 3:43 PM revealed she had worked in the facility until 03/30/22 when she was asked to leave when she arrived at work. Activity Assistant indicated she had placed her two weeks' notice into the facility prior to that morning and was scheduled to work through the end of March; however, on the morning of 03/30/22 she was sent home from the facility by the Administrator for not being fully vaccinated. The Activity Assistant stated she had worked all her scheduled shifts since the federal mandate for all healthcare staff to be fully vaccinated went into effect and had never been instructed she was not allowed to work if not vaccinated by the facility until that morning.

An interview with the Business Office Manager (BOM) on 3/31/22 at 1:00 PM revealed she was asked to begin collecting copies of staff

F 888

screening and tracked utilizing a master log. The Scheduler will notify agencies for direct care staff on submitting documentation on COVID-19 vaccination status for any new staff prior to working. Once obtained, vaccination dates will be entered in hosted time. Staff will be notified of facility vaccination clinics to sign up. The Administrator/Director of Nursing/Manager will ensure any staff who have not received this education or in compliance by May 3, 2022, will not be allowed to work until education completed. The Administrator/Director of Nursing/Nurse Manager will ensure newly hired staff, to include agency, complete education during facility orientation in person or via telephone during prior to working.

Quality Assurance. The Administrator/Director of Nursing/Nurse Manager will monitor using a Quality Assurance tool. The monitoring will include a sample of staff and vendors documented COVID-19 vaccination status. The QA monitoring will be conducted weekly x 12 weeks. The Administrator/Director of Nursing/Nurse Manager will report the results of the QA monitoring monthly to the Quality Assurance Performance Improvement (QAPI) committee for continued compliance and/or revision.

Completion Date- 5/3/22

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vaccination records to ensure all staff who entered the facility be fully vaccinated against COVID-19. The BOM indicated she had not received copies of all vaccination records for staff members who worked in the facility; however, she was in the process of attempting to collect these. The BOM stated she was not in charge of tracking staff vaccination status, only collecting copies of the cards. She explained she had transcribed the data provided to the survey team of staff who were vaccinated, and this list was for those she had a copy and to her knowledge the list was complete and accurate.

An interview with the Administrator on 3/31/22 at 6:00 PM revealed her understanding was the Director of Nursing had been tracking the staff COVID-19 vaccination records to ensure all staff who entered the facility were fully vaccinated. The Administrator stated she was the one responsible for reporting the vaccination rates into the NHSN website weekly. When asked about the reported 100% staff vaccination rate listed on the report, she indicated her understanding was that all staff who had worked since the mandate became effective had been vaccinated. She was not able to verify if copies of proof of vaccinations had been obtained for all staff members.

An interview with the Regional Director of Clinical Services (RDCS) on 4/1/22 at 3:15 PM revealed she was speaking on behalf of the Director of Nursing in her absence. The RDCS explained she was aware all staff members were to be fully vaccinated against COVID-19 and the facility was required to obtain and maintain documentation of verification of COVID-19 vaccination statuses for each person who worked in the facility. She stated she was unaware who in the facility

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F 888	Continued From page 99 currently tracked this information and was not aware anyone had worked in the facility without verification of their vaccination status.	F 888		