

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/21/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345226</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/18/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>PEAK RESOURCES-OUTER BANKS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>430 WEST HEALTH CENTER DRIVE NAGS HEAD, NC 27959</b>		
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E 000	Initial Comments  An unannounced recertification survey was conducted on 03/15/21 through 03/18/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #SDI911.	E 000			
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2)  §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.  §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.  §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.  §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.  §483.10(b)(1) The facility must ensure that the	F 550		4/15/21	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

04/08/2021

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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F 550	<p>Continued From page 1</p> <p>resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.</p> <p>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, staff interviews, and record review the facility failed to promote dignity by placing signage in residents' room which indicated residents had pressure ulcers and behaviors for 5 of 6 residents reviewed for dignity. (Resident #29, Resident #25, Resident #21, Resident #45, and Resident #34)</p> <p>Findings included:</p> <p>1. A review of Resident #29's minimum data set assessment dated 1/3/21 revealed she was assessed as severely cognitively impaired. She had no moods or behaviors. She required extensive assistance with bed mobility. Resident #29 was totally dependent on staff for transfers, locomotion on unit, dressing, eating toilet use, and personal hygiene. She was always incontinent of bowel and bladder. Her active diagnoses included diabetes mellites and stage 3 pressure ulcer of the sacral area.</p> <p>A review of Resident #29's care plan dated 2/15/21 revealed she was care planned to have a sacral pressure ulcer related to immobility and incontinence. The interventions included to assess the pressure ulcer for location, stage, size</p>	F 550	<p>Filling of this Plan of correction does not constitute an admission that the deficiencies alleged did, in fact, exist. This plan of correction is filed as evidence of the facility's desire to comply with the requirements and to continue to provide high quality of care.</p> <p>Affected Resident: Resident #29, Resident #25, Resident #21, Resident #45, and Resident #34 had signs removed on 03/17/21 by Director of Nursing. Resident #29, Resident #25, Resident #21, Resident #45, and Resident #34 continue to reside at the facility and did not suffer any adverse effects from the alleged deficient practice.</p> <p>Potentially Affected Resident: 100 % of the remaining resident beds were audited by the Rehabilitation Manager and the Director of Nursing on 03/17/2021 to observe for any additional signage that displayed resident specific medical information. 13 other residents were identified, and postings were immediately removed by the Rehabilitation Manager and/or the</p>		

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F 550	<p>Continued From page 2</p> <p>(length, width, and depth), presence/absence of granulation tissue, and epithelization weekly, provide incontinence care after each incontinent episode, and turn and reposition Resident #29 every 2 hours and as needed.</p> <p>During observation on 3/15/21 at 10:02 AM a sign was observed on the wall in the bedroom next to the door to the hall which read please turn or reposition resident every 2 hours secondary to current sacral pressure wound. Please do not leave resident in geri-chair longer than 2 hours. Please keep resident in the reclined position when not eating.</p> <p>During observation on 3/16/21 at 3:38 PM the sign was observed to still be in the resident ' s room.</p> <p>During observation on 3/17/21 at 10:32 AM the sign was observed to still be in the resident ' s room.</p> <p>During an interview on 3/17/21 at 10:05 AM Occupational Therapist #1 stated she and the wound care nurse who no longer worked at the facility would put signage up about what resident needs were in order to communicate to the nurse aides what care to do. She further stated she put the signage up in Resident #29 ' s room which indicated she had a pressure ulcer in order to communicate the need for repositioning to the nurse aides and the process worked well.</p> <p>During an interview on 3/17/21 at 10:48 AM the Director of Nursing stated signage was placed by therapy and they had to ask family or residents if it was okay to put signs up in the resident rooms. She further stated she was not aware of signage</p>	F 550	<p>Director of Nursing. Residents identified in 100% audit continue to reside at the facility and did not suffer any adverse effects from the alleged deficient practice. Measures/Systemic Changes: All licensed nursing staff and licensed therapy staff will be educated on resident right to privacy and dignity. This education will include the provision that signage with resident specific information will not be posted in the resident's room without the documented approval of the resident and/or resident representative. This education will be completed by 04/11/2021 by Staff Development Coordinator (SDC) or designee. Any licensed nursing staff or licensed therapy staff out on leave, vacation or PRN status will be educated upon return to their assignment by SDC or designee. Any new licensed nursing staff and/or licensed therapy staff will be educated during orientation on this practice by the Staff Development Coordinator and/or Rehabilitation Therapy Manager.</p> <p>Monitoring: A monitoring tool was developed to audit for any signage in resident rooms with resident specific information posted in public areas. The audit will determine if there is signage in a resident's room with resident specific medical information, that there is documentation in the medical record that the resident and/or resident representative has consented to the posting of this signage. The Director of Nursing or Rehabilitation Therapy Manager will randomly audit 20 resident rooms weekly for 4 weeks, then</p>		

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F 550	<p>Continued From page 3</p> <p>in the facility that identified wounds on the signage and there should be no signage that indicated if the resident had wounds. The Director of Nursing stated it would be a dignity concern for residents as it would not respect their privacy. Upon observing the signage, she concluded it should not have been posted in the room.</p> <p>2. A review of Resident #25's minimum data set assessment dated 1/1/21 revealed she was assessed as severely cognitively impaired. She required extensive assistance with bed mobility and eating. She was totally dependent on staff for dressing toilet use, and personal hygiene. She was always incontinent of bowel and bladder. Resident #25's active diagnosis included coronary artery disease, hypertension, hyperlipidemia, and dementia.</p> <p>A review of Resident #25's care plan dated 1/27/21 revealed she was care planned to require activities of daily living care. The interventions included to provide assistance with bed mobility and transfers.</p> <p>A review of Resident #25 ' s progress notes revealed her sacral pressure ulcer had resolved.</p> <p>During observation on 3/15/21 at 1:37 PM a sign above Resident #25 ' s bed read to increase skin integrity and promote healing of pressure ulcer please keep resident ' s head at 30 degrees or below when laying in bed, change position every 2 hours in bed, and change position every hour when in wheelchair.</p> <p>During observation on 3/16/21 at 8:50 AM the sign above Resident #25 ' s bed was still in place.</p>	F 550	<p>15 rooms every two weeks for 4 weeks, then 10 rooms monthly for 1 month. Continued audits will determine the need for further monitoring or alteration of the plan of correction. The results of these audits will be brought to QAPI meeting by the D.O.N. for review and recommendations monthly for the duration of the monitoring.</p>		

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F 550	<p>Continued From page 4</p> <p>During observation on 3/16/21 at 2:47 PM the sign above Resident #25 ' s bed was still in place.</p> <p>During observation on 3/17/21 at 10:33 AM the sign above Resident #25 ' s bed was still in place.</p> <p>During an interview on 3/17/21 at 10:05 AM Occupational Therapist #1 stated she and the wound care nurse who no longer worked at the facility would put signage up about what resident needs were in order to communicate to the nurse aides what care to do. She further stated she put the signage up in Resident #25 ' s room which indicated she had a pressure ulcer in order to communicate the need for repositioning to the nurse aides and the process worked well.</p> <p>During an interview on 3/17/21 at 10:48 AM the Director of Nursing stated signage was placed by therapy and they had to ask family or residents if it was okay to put signs up in the resident rooms. She further stated she was not aware of signage in the facility that identified wounds on the signage and there should be no signage that indicated if the resident had wounds. The Director of Nursing stated it would be a dignity concern for residents as it would not respect their privacy. Upon observing the signage, she concluded it should not have been posted in the room.</p> <p>3. Resident # 45 was admitted to the facility on 11/19/18 with diagnoses that included cerebral infarct, hemiplegia, dysphagia, asphasia, depression and pain.</p> <p>Review of the annual Minimum Data Set dated 10/16/20 revealed Resident # 45 had short- and long-term memory problems and moderately impaired decision-making skills. He required total to extensive assistance with activities of daily</p>	F 550			

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F 550	<p>Continued From page 5</p> <p>living. He was assessed as having upper extremity impairment on one side and having lower extremity impairment on both sides.</p> <p>During an observation on 3/16/21 at 2:52 PM a sign above Resident # 45 ' s bed read "please leave resident ' s feet uncovered or utilize foot tent! Thank you! OT."</p> <p>During an observation on 3/17/21 at 11:02 AM the sign above Resident #45 ' s bed was still in place.</p> <p>During an interview on 3/17/21 at 10:05 AM the Occupational Therapist #1 stated she and the wound nurse who no longer worked at the facility would put signage up about what residents needs were in order to communicate to the nurse aides what care to do.</p> <p>During an interview on 3/17/21 at 10:51 AM the Director of Nursing stated signage was placed by therapy and they had to ask family or residents if it was okay to put signs up in the resident rooms. She stated she was not aware that the Occupational Therapist had placed a sign in Resident #45 ' s room.</p> <p>4. Resident #21 was admitted to the facility on 07/11/20 with diagnoses that included vascular dementia, anxiety and adjustment disorder.</p> <p>Review of the Quarterly Minimum Data Set assessment dated 1/2/21 revealed Resident #21 had significant cognitive impairment. She required extensive assist with 2-person physical assistance for her Activities of Daily Living (ADLs).</p> <p>During an observation on 03/15/21 at 11:13 AM, signage on the bathroom door indicated provide</p>	F 550			

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F 550	<p>Continued From page 6</p> <p>resident cat in order to increase sensory stimulation, decrease adverse behaviors and improve quality of life. The signage was visible from the hallway and had resident specific information that revealed Resident #21 had adverse behaviors.</p> <p>An interview on 03/17/21 at 8:45AM with the Occupational Therapist (OT) revealed she was familiar with Resident #21 and had provided therapy services for sensory integration, decrease adverse behaviors and coping strategies. OT further revealed they provided Resident #21 with a Twiddle-Cat to re-direct resident and reduce pinch and grab tendencies. OT revealed they had placed the signage in Resident#21's room.</p> <p>During an interview on 3/17/21 at 10:51AM the Director of Nursing stated signage was placed by therapy and they had to ask family or residents if it was okay to put signs up in the resident rooms. She stated she was not aware that the Occupational Therapist had placed a sign in Resident #21's room. The DON revealed Resident#21's Responsible Party had been notified of the signage and had given permission to place the signage.</p> <p>5. A review of Resident #34's Annual MDS assessment dated 1/5/2021 revealed he was assessed as moderately cognitively impaired. He required extensive assistance with one-person physical assistance with bed mobility, dressing and personal hygiene. Resident #34 was totally dependent on staff for transfers, bathing, and toilet use.</p> <p>A review of Resident #34's care plan last updated</p>	F 550			

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F 550	Continued From page 7 3/9/2021 revealed she was care planned for pressure ulcer to sacrum related to immobility. The interventions included to turn and reposition Resident #34 every 2 hours as needed, apply house barrier cream to buttocks area after each incontinent episode.  During an observation on 3/15/2021 at 2:19 PM a sign was observed on the wall above Resident #34's bed next to the door leading to the unit hallway. The note read; "Pressure Ulcer Education" and a yellow sticky note was attached that read "I have a pressure injury, please be dear and place me in my side unless I am eating."  During an observation on 3/16/2021 at 9:39 AM the sign was observed to still be in the resident's room.  During the observation on 3/17/2021 at 10:28 AM the sign was observed to still be in the resident's room.  During an interview on 3/17/2021 at 10:48 AM the Director of Nursing stated signage was placed by therapy and the wound nurse that was no longer there. The DON stated she was not aware of signage in the facility that identified wounds. The DON stated the signage would be a dignity concern for residents. The DON observed the signage and stated it should not have been posted in the room.	F 550			
F 575 SS=E	Required Postings CFR(s): 483.10(g)(5)(i)(ii)  §483.10(g)(5) The facility must post, in a form and manner accessible and understandable to	F 575			4/11/21

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F 575	<p>Continued From page 8</p> <p>residents, resident representatives:</p> <p>(i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and</p> <p>(ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and staff and resident interviews, the facility failed to post the required posting of a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups, or a statement the resident may file a complaint with the State Survey Agency.</p> <p>Findings included:</p> <p>During a resident council meeting on 3/17/21 at 9:55AM, the 5 resident council members that attended the meeting, revealed there was no signage in the facility with State agency information. The 5 residents revealed they were not aware they could file a complaint with the</p>	F 575	<p>Filling of this Plan of correction does not constitute an admission that the deficiencies alleged did, in fact, exist. This plan of correction is filed as evidence of the facility's desire to comply with the requirements and to continue to provide high quality of care.</p> <p>Affected Resident:</p> <p>No residents were affected by the alleged deficient practice. The required posting with a list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective</p>		

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F 575	<p>Continued From page 9</p> <p>State Survey Agency nor how to file a complaint.</p> <p>An interview with the Social Worker on 3/17/21 at 10:36AM revealed she provided signage on grievances and the Ombudsman contact information, which was located outside her office.</p> <p>An observation of the posting outside the Social Worker's office on 3/17/21 at 10:37AM revealed posting of Resident Right information with the contact information for the Ombudsman and a posting on the grievance policy and how to file a grievance. The posting was visible to staff and residents.</p> <p>A tour of the facility, with the Administrator, on 3/17/21 at 10:45AM, revealed no signage on State Agency contact information was posted in the facility. During the tour of the facility, postings for the local Nursing Home Community Advisory Committee were observed. These posting were visible and accessible to residents and staff.</p> <p>An interview with the Administrator on 3/17/21 at 10:50AM, revealed signage with State Agencies contact information should be posted and visible. The Administrator stated the signage must have been removed during COVID Outbreaks.</p>	F 575	<p>services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit was posted in a picture frame on the wall in the hallway upon entering the facility. The required posting of a statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements and requests for information regarding returning to the community was posted on the Resident Board located at nurse station one. In addition, the same a list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit and the statement is in the resident/family handbook which is provided to all residents upon admission. The required posting of a statement that the resident may file a complaint with the</p>		

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F 575	Continued From page 10	F 575	<p>State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements and requests for information regarding returning to the community is in the resident/family handbook which is provided to all residents upon admission.</p> <p>The Administrator did show the surveyor the postings during the survey. In addition, the Admissions Coordinator was interviewed and stated this information is in the Resident Handbook and is given to every resident/representative upon admission.</p> <p>Potentially Affected Resident: No resident was affected by the alleged deficient practice, as the signage was posted and is in the resident handbook.</p> <p>Measures/Systemic Changes: The Administrator was educated by the Regional Clinical Manager on 3/22/2021 that the facility must post, in a form and manner accessible and understandable to residents, resident representatives a list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/21/2021  
FORM APPROVED  
OMB NO. 0938-0391

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F 575	Continued From page 11	F 575	<p>based service programs, and the Medicaid Fraud Control Unit. In addition, the facility must post a statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements and requests for information regarding returning to the community.</p> <p>The Activities Director was educated by the Administrator on 04/05/2021 that residents need to be informed during the Resident Council meetings regarding the above postings. The Activities Director informed residents at the Resident Council meeting the information regarding the location of the postings and the information included on the postings on 03/30/2021. Activity Director will continue to mention this at future Resident Council meetings.</p> <p>Monitoring: A monitoring tool was developed to monitor that the mandatory postings above are in place weekly for 4 weeks, then every two weeks for 4 weeks, then monthly for 1 month. Continued audits will be determined based on results of prior months of audits. The results of these audits will be brought to QAPI meeting by the Administrator for review and further recommendations monthly for the duration of the monitoring.</p>		

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F 656 F 656 SS=D	Continued From page 12 Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)  §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate	F 656 F 656		4/11/21	

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F 656	<p>Continued From page 13 entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop a Care plan for oral care for one of one residents reviewed for dental care (Resident # 45) and failed to provide restorative therapy according to the plan of care for 1 of 2 residents reviewed for range of motion. (Resident #35).</p> <p>The findings included:</p> <p>1. Resident # 45 was admitted to the facility on 11/19/18 with diagnoses that included cerebral infarct, hemiplegia, dysphagia, aphasia, depression and pain.</p> <p>Review of the annual Minimum Data Set dated 10/16/20 revealed Resident # 45 had short- and long-term memory problems and moderately impaired decision-making skills. He required total to extensive assistance with activities of daily living and was coded for obvious or likely cavity or broken natural teeth. He was assessed as having upper extremity impairment on one side.</p> <p>Review of Resident # 45 ' s care plan dated 11/19/18 and last updated on 5/23/2021 revealed the resident had a care plan for nutritional status. Interventions included encourage drinks in two handle cups, encourage fluids, RD/dietary consult as needed, diet; likes finger foods, encourage weight as ordered, record meal and fluid intake every shift.</p>	F 656	<p>Filling of this Plan of correction does not constitute an admission that the deficiencies alleged did, in fact, exist. This plan of correction is filed as evidence of the facility's desire to comply with the requirements and to continue to provide high quality of care.</p> <p>Affected Resident: Resident #45 care plan was updated to address oral care on 03/17/2021 by the MDS (Minimum Data Set) nurse #1. The restorative plan implemented for resident #35 had care plan updated and restorative plan implemented on 04/07/2021 by MDS Nurse #1. No adverse outcomes related to care plan compliance. Potentially Affected Resident: MDS nurse #1 and MDS nurse #2 audited all assessments from October to present to ensure care plans in place for every CAA triggered on 04/02/2021. Care plans were reviewed for residents receiving restorative therapy 04/06/2021. 9 other residents identified had care plan updated to reflect restorative therapy by MDS Nurse #1 on 04/07/2021. Measures/Systemic Changes: Administrator educated both MDS coordinators that all residents should have a comprehensive and accurate care plan based on the needs of the resident as</p>		

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F 656	<p>Continued From page 14</p> <p>Review of Resident # 45 ' s care plan dated 12/07/18 and last updated on 5/23/21 revealed the resident had a care plan for behavioral symptoms. Interventions included approach resident in calm manner, monitor behaviors frequently and refer to psychiatrist as needed.</p> <p>Review of the residents Comprehensive Care Plan dated 11/19/18 and last revised on 5/23/21 contained no information or interventions regarding oral care.</p> <p>During an observation on 3/15/21 at 12:25 PM Resident # 45 was observed eating lunch in his room. His right upper and lower jaw were observed to have black jagged teeth and he was missing teeth on both his upper and lower jaws.</p> <p>During an observation on 3/15/21 at 3:20 PM Resident # 45 was observed sitting up in bed. His right upper and lower jaw were observed with black jagged teeth and he was missing teeth on both his upper and lower jaws.</p> <p>In an interview on 3/17/21 at 9:37 AM nursing assistant (NA) # 5 stated Resident # 45 would not let staff brush his teeth or use a sponge swab to clean his teeth.</p> <p>In an interview on 3/17/21 at 10:32 AM NA # 6 stated the resident refused ADL care and all oral care. She stated the resident did not like to have his face washed or his teeth brushed. The NA stated staff tried to provide oral care, but the resident would not allow them to brush his teeth.</p> <p>During an interview on 3/17/21 at 11:40 AM the MDS Nurse stated she did not see a care plan for</p>	F 656	<p>identified in the comprehensive assessment. This was completed on 04/06/2021. This education was approved by the Regional Reimbursement Manager on 4/06/2021 and consisted of the following: The function of care plan; care plans must be individualized and person-centered; care plans are a working tool and must be updated as needed to reflect the care provided to the resident. The Staff Development Coordinator (SDC) will educate all Certified Nursing Assistants (CNA's) on the importance of following the care plan for each resident on restorative therapy. All C.N.A's will be educated on restorative care, including ROM exercises and to ensure that this care is provided as written in the care plan and resident profile. This will be completed by 04/11/2021. Any C.N.A out on leave, vacation or PRN status will be educated upon return to their assignment by SDC or designee. Newly hired CNA's will be educated during orientation by the SDC.</p> <p>Monitoring: An audit tool was created to monitor accuracy of care plans and to monitor that care plan interventions are being followed. MDS Nurse #1 and MDS Nurse #2 will audit 25% of care plans to ensure that these care plans are comprehensive, accurate and person-centered weekly x 4 weeks, then monthly x 3 months. The RN Supervisor and SDC will be auditing residents to ensure that care plan interventions are being followed with Restorative care. They will complete</p>		

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F 656	<p>Continued From page 15</p> <p>oral care for the resident. The MDS nurse indicated Resident # 45 had behaviors and she had care planed his refusal of laboratory test and weights under behaviors. She stated she could have care planed his oral care under the behaviors as well.</p> <p>2. Resident #35 was admitted to the facility on 4/20/15.</p> <p>A review of Resident #35's Minimum Data Set assessment dated 1/5/21 revealed she was assessed as moderately cognitively impaired. She had no moods and no behaviors. Resident #35 required extensive assistance with personal hygiene, eating, and bed mobility. She was totally dependent on staff for transfers, locomotion on and off unit, dressing, and toilet use. Her active diagnoses included stroke, hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right dominant side, and dementia.</p> <p>A review of Resident #35's care plan dated 1/25/21 revealed she was care planned to receive restorative active range of motion. This intervention was initiated on 5/9/19. The interventions included to have Resident #35 lift bilateral knees 10 times, have resident bend, and straighten bilateral knees 10 times, and have resident move bilateral ankles up and down 10 times.</p> <p>A review of Resident #35's restorative nursing range of motion charting from 3/11/21 through 3/16/21 revealed on 3/12/21 she received 15 minutes of active range of motion. It was not documented that she received any other restorative active range of motion during that time.</p>	F 656	<p>audits on 50% of residents on restorative therapy daily for two weeks, weekly for one month and monthly for two months. Continued audits will be based on results of prior 4 months of audits. The results of the audits will be brought to QAPI meetings by the MDS Coordinator and SDC for review and further recommendations.</p>		

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F 656	Continued From page 16  During an interview on 3/16/21 at 4:39 PM Nurse Aide #2 stated the floor nurse aides do not perform restorative care for residents. She concluded she did not know if the facility had a restorative program and she had not performed restorative therapy to Resident #35.  During an interview on 3/17/21 at 7:48 AM Nurse Aide #3 stated she did not know if there was a restorative nurse aide, however she stated she did not perform restorative therapy with the residents including Resident #35.  During an interview on 3/17/21 at 7:53 AM Nurse Aide #4 stated the floor nurse aides do not perform active range of motion or restorative therapy. She further stated there was a restorative aide sometimes but to her knowledge there was not a restorative aide in the facility this week. She concluded she did not perform any restorative active range of motion with Resident #35.  During an interview on 3/17/21 at 8:09 AM Nurse #2 stated the nurses did not perform any restorative therapy with any of the residents including Resident #35.  During an interview on 3/17/21 at 8:11 AM the Director of Nursing stated that currently floor nurse aides were to do the restorative therapy as the restorative nurse aide had begun to work only part time. She further stated if restorative range of motion was in Resident #35's plan of care and the nurse aides were supposed perform active range of motion with Resident #35. She concluded she was not aware the nurse aides did not know they were to perform restorative care	F 656			

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F 656	Continued From page 17 and it was not done as it should have been for Resident #35.  During an interview on 3/17/21 at 10:05 AM Occupational Therapist #1 stated it was an expectation that when a resident is put on restorative therapy upon discharge that it would be carried out by the nursing aide staff or the restorative team if there was one.	F 656			
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)  §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted 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	F 761		4/11/21	

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F 761	<p>Continued From page 18</p> <p>by: Based on observation and staff interview the facility failed to date an opened bottle of Tubersol in the medication refrigerator for 1 of 1 medication storage room reviewed. The facility failed to label medications with an open date on 2 of 2 medication carts reviewed for medication storage. (400-Hall and 100-Hall)</p> <p>The findings included:</p> <p>An observation was conducted of medication storage room 2 on 3/17/2021 at 8:39 AM. A bottle of opened Tubersol 5TU/0.1ml was found in the medication refrigerator without an open date. The Tubersol bottle read discard product 30 days after opening.</p> <p>An interview with the Director of Nursing (DON) on 3/17/2021 at 8:44 AM revealed that the medication bottle should have had an open date.</p> <p>During an observation of the 400-hall medication cart on 3/17/2021 at 1:53 PM 1 opened bottle of Timolol Maleate (for glaucoma) with no open date and 1 opened bottle of Travoprost 0.0004% (for glaucoma) with no open date for Resident # 5.</p> <p>An interview conducted with Nurse #3 on 3/17/2021 at 2:03 PM revealed there should be an open date on all eye drops because some expire in 2 weeks and others in 6 weeks.</p> <p>During an observation of the 100-hall medication cart on 3/17/2021 at 2:08 PM 1 opened bottle of Olopatadine HCL 0.1% with no open date for Resident # 51 (for itchy eyes) and 1 opened bottle of Children's Alaway with no open date for Resident #50.</p>	F 761	<p>Filing the plan of correction does not constitute that the alleged deficiencies did in fact exist. The plan of correction is filed as evidence of the facility's desire to comply with the requirements and to continue to provide high quality of care.</p> <p>Affected Resident: The identified, opened, undated medications were removed from the medication room and medication carts immediately by the Director of Nursing on 03/17/2021. There have been no adverse effects to any residents.</p> <p>Potentially Affected Resident: All medication carts and medication rooms were audited by the Staff Development Coordinator and the Director of Nursing on 03/17/2021 and no other opened, undated medications were identified. No residents were affected by the alleged deficient practice.</p> <p>Measures/Systemic Changes: All Licensed Nursing staff will be educated by the DON and/or Staff Development Coordinator by 04/11/2021 regarding the importance of dating any medication when it is opened. In addition, the education will include that any opened medications that are not dated will be immediately removed from the medication cart and/or medication room.</p> <p>Any licensed nurse out on leave, vacation or PRN status will be educated upon return to their assignment by SDC and/or designee. Newly hired licensed nursing staff will be educated on this practice during orientation by the Staff</p>		

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F 761	Continued From page 19  An interview conducted with Nurse #1 on 3/17/2021 at 2:16 PM revealed that opened eye drops could be used until the expiration date on the bottle.  An interview with the DON on 3/17/2021 at 2:28 PM revealed that eye drops are to have an opened date when seal is broken.	F 761	Development Coordinator and/or Director of Nursing. Monitoring: An audit tool was developed to monitor that medications are being dated upon opening. Audits will be completed by the Staff Development Coordinator and/or Nursing Supervisor on 2 randomly selected medication carts and both medication rooms weekly for 12 weeks. The current practice for monthly pharmacy consultant visits is to also ensure that all opened medications are dated. The pharmacy consultants will continue to monitor that all opened medications are properly dated when opened and will provide a report of their findings to the Director of Nursing. Continued audits will be determined based on results of prior months of audits. These results of these audits will be brought to the QAPI meeting by the DON for review and further recommendations monthly for the duration of the monitoring.		
F 812 SS=E	Food Procurement, Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)  §483.60(i) Food safety requirements. The facility must -  §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility	F 812		4/11/21	

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F 812	<p>Continued From page 20</p> <p>gardens, subject to compliance with applicable safe growing and food-handling practices.</p> <p>(iii) This provision does not preclude residents from consuming foods not procured by the facility.</p> <p>§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:</p> <p>Based on observations and staff interviews the facility failed to maintain kitchen equipment clean and in a sanitary condition by failing to clean six of six baking sheets, four of four half size steam table pans, three of three full size steam table pans and by failing to clean 2 of 2 convection ovens.</p> <p>The findings included:</p> <p>A review of the undated Area and Equipment Cleaning Frequency, Kitchen Area Policy, under Equipment/ Area/Tasks/ Comments, read as: Ovens-Outside- Clean and Sanitize-Daily. Ovens Inside- Clean and Sanitize Daily. Ovens-Inside-Clean and Sanitize-Weekly.</p> <p>During the initial tour on 3/15/2021 at 10:55 AM the dish room drying rack was observed. Six baking sheets were observed stacked on the drying rack ready for use. The six baking sheets were observed to have 1/8-inch to 1/4-inch of black food residue one inch wide under the rim. Stacked on the drying rack ready for use, 4 of 4 half size steam table pans and 3 of 3 full size steam table pans were observed with black food residue under the rim of the pans. Two of the two convection ovens were observed with black charred food particles on the bottom of the ovens and the inner rim of the convection ovens doors</p>	F 812	<p>This Plan of Correction constitutes written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists. This Plan of Correction is submitted to meet requirements established by state and federal law.</p> <p>Affected Resident: The oven was deep cleaned. The identified pots and pans were six of six baking sheets, four of four steam table pans, 2 convection ovens. (food particles on the bottom of the oven and the inner rims of the doors with black grease build up). All of the items were deep cleaned to remove carbon build up on 03/17/2021 by the Dietary Manager and Cook #1. No residents were adversely affected by the alleged deficient practice.</p> <p>Potentially Affected Resident: Regional Dietary Manager and facility Dietary Manager audited all baking sheets, steam table pans and other pots and pans on storage racks for food particles or carbon buildup. Any items with food particles were immediately deep cleaned by the Dietary Manager or dietary</p>		

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F 812	<p>Continued From page 21</p> <p>were observed with black grease build up.</p> <p>A second observation of the kitchen on 3/16/2021 at 2:34 PM revealed the convection ovens were in the same condition. The drying rack was observed to have 3 of 3 full size steam table pans, and 3 of 3 half size steam table pans were observed with black food residue under the rim of the pans and 4 of 4 baking sheets with 1/8-inch to 1/4-inch of black food residue one inch wide under the rim.</p> <p>A third observation of the kitchen on 3/17/2021 at 1:26 PM revealed the convection ovens and steam table pans were in the same condition.</p> <p>In an interview on 3/17/21 at 1:28 PM the day cook stated the convection oven was cleaned weekly, but another worker had spilled something in the oven and did not clean it up. The day cook indicated the ovens should be wiped out daily.</p> <p>In an interview on 3/17/21 at 1:33 PM the District Dietary Supervisor stated the convection ovens should be cleaned after any spill. She stated the baking sheets and steam table pans could be cleaned with a degreaser and staff would clean them that day.</p> <p>On 3/17/21 at 2:59 PM the Administrator stated she would expect the kitchen to be clean.</p>	F 812	<p>staff. Some pans were discarded and replaced. This was completed on 03/17/2021. No residents were affected by the alleged deficient practice.</p> <p>Measures/Systemic Changes: The Dietary Manager educated all dietary staff on deep cleaning stack ovens, wiping down stack ovens, removing carbon build up off pots and pans, daily removal of grease build-up and cleaning schedules. All education was completed on 3/23/21. Any dietary staff out on leave, vacation, or PRN status will be educated prior to returning to their assignment by the Dietary Manager. Newly hired dietary staff will be educated during orientation by the Dietary Manager.</p> <p>Monitoring: An audit tool was developed to monitor pots and pans, steam tables and stack ovens to ensure that there are no food particles, built up grease or carbon build up. Random audits of these items will be conducted by the Dietary Manager or his designee daily for 4 weeks, weekly for four weeks, then monthly x 1 month. Continued audits will be determined based on results of prior months of audits. The results of these audits will be brought to the QAPI meeting monthly by the Dietary Manager for review and further recommendations.</p>		
F 880 SS=E	<p>Infection Prevention &amp; Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)</p> <p>§483.80 Infection Control The facility must establish and maintain an infection prevention and control program</p>	F 880		4/11/21	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 880	<p>Continued From page 22</p> <p>designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</p> <p>§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§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;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the</p>	F 880			

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F 880	<p>Continued From page 23</p> <p>least restrictive possible for the resident under the circumstances.</p> <p>(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</p> <p>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§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 resident and staff interviews, the facility failed to screen a vendor upon entrance, and implement their infection control policies and the Centers for Disease Control and Prevention (CDC) guidelines for the use of Personal Protective Equipment (PPE) when Nurse Aide #1 entered resident room without wearing gloves for 1 of 1 resident with transmission-based precautions (Resident #169) and Nurse #3 administered medications to a resident with her face mask below her nose (Resident #54) for two of two staff members observed for infection control practices. In addition, the facility failed to offer hand hygiene prior to meals for 2 of 2 residents observed</p>	F 880	<p>Filing the plan of correction does not constitute that the alleged deficiencies did in fact exist. The plan of correction is filed as evidence of the facility's desire to comply with the requirements and to continue to provide high quality of care.</p> <p>F880 Affected Resident: The Maintenance Assistant and Maintenance Director were educated by the Administrator on 3/19/2021 on completing vendor screening and only entry of vendors via front door. Nurse #3 was educated immediately by Director of Nursing on donning PPE-face mask to</p>		

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F 880	<p>Continued From page 24</p> <p>during meal tray delivery (Resident #59 &amp; Resident #61). This failure occurred during the COVID19 pandemic.</p> <p>Findings included:</p> <p>1. Review of the facility's COVID-19 Employee/Visitor Screening Form Guidelines, no date, revealed anyone entering the facility will complete the appropriate screening form based on the reason for entering the facility.</p> <p>An observation on 3/15/21 at 12:45PM revealed Maintenance Staff #1 opened the dining room entrance and permitted a vendor into the facility. It was further observed that 7 residents were participating in an activity in the dining room. The residents were eating and had no masks on when the vendor was permitted access into the dining room. The vendor was observed wearing a mask. The vendor walked within 6 feet of the residents participating in the activity.</p> <p>An interview with Maintenance Staff #1 on 3/18/21 at 4:08PM, revealed he had unlocked the dining room door for the vendor. He further stated all vendors were to be screened at the main entrance to include a temperature check and questionnaire. The Maintenance Staff #1 revealed he had been instructed by the Maintenance Supervisor to open the door and allow the vendor into the building. He further stated the Maintenance Supervisor was with the vendor when he opened the door. The Maintenance Staff #1 stated he was trained that all vendors were required to complete a screening at the main entrance prior to access to the facility.</p> <p>During an interview with the Receptionist on</p>	F 880	<p>ensure nose and mouth covered properly on 03/17/2021. Nurse Aide #1 was educated on appropriate PPE for Enhanced droplet precautions and Infection Control precautions on 04/08/2021 by Director of Nursing, to include wearing gloves when delivering meal trays. There have been no adverse effects to any residents.</p> <p>Potentially Affected Resident: No residents were affected by the alleged deficient practice.</p> <p>Measures/Systemic Changes: Policy titled Infection Control Precaution dated March 2020 was reviewed by the Corporate Clinical manager on 04/08/2021. No changes were indicated. The Director of Nursing in-serviced all staff on proper infection precautions, proper use of PPE on 04/08/2021. Any staff out on leave, vacation or PRN status will be educated upon return to their assignment by SDC and/or designee. Newly hired licensed nursing staff will be educated on this practice during orientation by the Staff Development Coordinator and/or designee. Newly hired employees will be educated during orientation by the SDC. Infection Preventionist educated all Department Heads and Dietary staff on vendor screening and vendors must enter and exit through front entrance on 3/24/2021. Any staff out on leave, vacation or PRN status will be educated upon return to their assignment by SDC and/or designee. Newly hired department heads and dietary staff will be educated during orientation by the SDC.</p>		

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F 880	<p>Continued From page 25</p> <p>3/15/21 at 1:00PM, it was revealed no screenings had been completed on vendors on this date. The Receptionist further stated all staff, visitors, and vendors were required to enter through the main entrance. She indicated vendors were required to be screened prior to being permitted access into the facility.</p> <p>An interview with the Maintenance Supervisor on 3/15/21 at 1:05PM revealed vendors were to be screened prior to entrance into the building. He further stated the vendor should not have been allowed entrance through the dining room door.</p> <p>An interview with the Infection Preventionist on 3/15/21 at 2:12PM revealed COVID19 screening was performed at the main entrance into the facility. She stated all staff, visitors and vendors must be screened. She further revealed training was conducted on 9/4/20 to include how, when and where screening of staff, visitors and vendors occurred. All staff members were part of this training, including the maintenance staff.</p> <p>During an interview with the Director of Nursing on 3/17/21 at 2:12PM, she stated when a vendor came into the building, they were to be screened. She indicated screening occurred at the main entrance into the facility. The DON further stated staff were not permitted to allow vendors entrance through a side door.</p> <p>2.a. Review of the "PPE Use Guidelines during COVID Pandemic" revised 2/13/21 revealed the facility followed all current guidelines for infection control and prevention.</p> <p>Resident #169 was admitted to the facility on 3/3/21 from the hospital and was placed on Enhanced Droplet Precautions for the 14-day</p>	F 880	<p>Infection Preventionist educated all nursing staff and therapy on hand hygiene prior to passing out meal trays on 03/24/2021. Any nursing or therapy staff out on leave, vacation or PRN status will be educated upon return to their assignment by SDC and/or designee. Newly hired nursing staff and therapy will be educated during orientation by the SDC.</p> <p>Monitoring: The facility also implemented a monitoring tool to audit staff compliance with proper use of PPE and hand hygiene i.e., providing meal trays, passing medication. Audits to be completed random shifts for 5 employees 5 times per week for 1 month, twice weekly for four weeks, weekly for 1 month then PRN thereafter to ensure compliance by the Infection Preventionist or designee.</p> <p>The facility also implemented a monitoring tool to audit staff compliance with screening in vendors and keeping other facility entry doors locked. Audits to be completed 3 times a week for 4 weeks, 2 times a week for 4 weeks and weekly for 4 weeks by Maintenance Director or designee.</p> <p>Continued audits will determine the need for further monitoring or alteration of the plan of correction. Infection Preventionist will bring these tools to be reviewed daily in the stand-up meeting and monthly at QAPI to evaluate the effectiveness of the above plan.</p>		

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F 880	<p>Continued From page 26</p> <p>quarantine period.</p> <p>Review of the Enhanced Droplet Isolation signage on Resident #169's door revealed before entering this room, follow the instructions below. The instructions stated staff should don a mask, eye protection, gown, and gloves prior to entering the resident room.</p> <p>An observation on 3/15/21 at 12:20PM revealed NA #1 entered Resident #169's room to deliver a meal tray. NA #1 was wearing a mask, donned a gown, entered the resident room and delivered the lunch meal. NA #1 doffed the gown prior to exiting Resident #169's room. NA #1 applied Alcohol Based Hand Rub (ABHR) after exiting the resident room.</p> <p>During an interview on 3/15/21 at 12:22PM with NA #1, she stated she was not required to wear gloves when providing a meal tray for residents on Enhanced Droplet Precautions (EDP).</p> <p>An interview with Nurse #1 on 3/15/21 at 12:40PM revealed staff were to don Personal Protective Equipment (PPE) each time staff entered a resident room who was on EDP. She further revealed PPE included a mask, gown, and gloves. Nurse #1 stated staff were trained to wear gloves when entering resident rooms on EDP. She further stated the NA was trained to wear gloves when passing trays.</p> <p>During an interview with the Director of Nursing (DON), she stated staff were to don PPE which included a mask, gown, and gloves each time they entered a resident room who was on EDP. She further stated staff should doff the PPE in the resident room and then apply Alcohol Based Hand Rub (ABHR). The DON stated NA #1 was educated on how to pass trays for residents on</p>	F 880			

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F 880	<p>Continued From page 27</p> <p>EDP, which included donning gloves.</p> <p>3. During observation on 3/15/21 at 12:44 PM Nurse #1 was observed to enter Resident #59 ' s room and provide the resident their meal tray. She set up the food tray for the resident and left the room. She did not offer hand hygiene to the resident. The resident began to eat without performing hand hygiene.</p> <p>During an interview on 3/15/21 at 12:47 PM Nurse #1 stated she would help with passing meal trays when it was needed. She further stated she did not think to offer hand hygiene to the residents prior to passing trays but understood it was important and she would begin to do so.</p> <p>During an interview on 3/16/21 at 8:24 AM the Director of Nursing stated residents should be offered hand hygiene for infection control purposes before eating.</p> <p>4. During observation on 3/15/21 at 12:31 PM Nurse #1 was observed to assist passing meal trays. She was observed to enter Resident #61 ' s room with his meal tray. She set the meal tray down and asked if the resident needed to sit up, and he indicated he did. She requested Nurse Aide #1, who was passing by in the hall, assist her with the resident. They assisted the resident up and Nurse #1 and Nurse Aide #1 exited the resident ' s room without offering the resident hand hygiene. Resident #61 began to eat without performing hand hygiene.</p> <p>During an interview on 3/15/21 at 12:34 PM Nurse Aide #1 stated staff were to offer hand hygiene to residents before meals. She</p>	F 880			

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F 880	<p>Continued From page 28</p> <p>concluded she was not aware Nurse #1 had not offered hand hygiene to the resident before she had entered the room to assist with positioning.</p> <p>During an interview on 3/15/21 at 12:47 PM Nurse #1 stated she would help with passing meal trays when it was needed. She further stated she did not think to offer hand hygiene to the residents prior to passing trays but understood it was important and she would begin to do so.</p> <p>During an interview on 3/16/21 at 8:24 AM the Director of Nursing stated residents should be offered hand hygiene for infection control purposes before eating.</p> <p>2b. Review of the facility's policy "Personal Protective Equipment (PPE) Use During COVID Pandemic" last revised 2/13/2021 read in part:" A well-fitting facemask would be worn by healthcare professionals for source control while in the facility and for protection during patient care encounters."</p> <p>During an observation on 3/17/21 at 8:08 AM Nurse #3 was observed at the 100 Hall medication cart preparing medication for Resident #3. The nurse's face mask was observed to be resting below her nose.</p> <p>An interview was conducted with Nurse #3 at 8:12 AM. The nurse pulled the mask up to cover her nose and stated that the mask was always to be worn over her nose and mouth while in the facility.</p> <p>During an observation of 3/17/21 at 10:34 AM Nurse #3 was observed at the 100 Hall medication cart preparing medication for</p>	F 880			

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F 880	Continued From page 29 Resident #54 with the mask resting below her nose. The nurse left the medication cart and entered into Resident #54's room. The nurse administered resident's medication with mask below her nose. The nurse washed her hands and returned to the medication cart with mask resting below her nose.	F 880			
F 914 SS=D	An interview on 3/17/21 at 10:41 AM with the Director of Nursing revealed that staff should always wear their mask while in the facility. Bedrooms Assure Full Visual Privacy CFR(s): 483.90(e)(1)(iv)(v)  §483.90(e)(1)(iv) Be designed or equipped to assure full visual privacy for each resident;  §483.90(e)(1)(v) In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to provide privacy curtains in resident rooms to provide full visual privacy for three of six rooms observed on the 100 hall (Room # ' s 102, 105, 111). The findings included:  1. During an observation on 3/16/2021 at 2:51 PM, revealed there were no privacy curtains hung in room 102, to provide privacy for either resident in Bed A or Bed B.  Observation on 3/16/2021 at 2:55 PM in room 111	F 914	This Plan of Correction constitutes written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists. This Plan of Correction is submitted to meet requirements established by state and federal law.  Affected Resident: Room #102, #105 and #111 had privacy curtains hung up on 03/17/2021 by Housekeeping Manager. No residents	4/11/21	

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F 914	<p>Continued From page 30</p> <p>revealed there was no privacy curtain for Bed A.</p> <p>2. Observation on 3/17/21 at 10:34 AM revealed there were no privacy curtains hung in room 102, to provide privacy for either resident in Bed A or Bed B.</p> <p>Observation on 3/17/21 at 10:36 AM in Room 111 revealed there was no privacy curtain for Bed A.</p> <p>Observation on 3/17/21 at 2:06 PM in Room 105 revealed there was no privacy curtain for Bed A.</p> <p>In an interview on 3/17/2021 at 2:11 PM the Housekeeping manager revealed if staff saw any dirty, torn or missing privacy curtains they should notify him, and he would take care of it right away.</p> <p>On 3/17/21 at 2:53 PM the Administrator stated she would expect all residents to have privacy curtains. She indicated housekeeping staff should have reported the curtains were missing.</p>	F 914	<p>were adversely affected by the alleged deficient practice.</p> <p>Potentially Affected Resident: Housekeeping Manager did a 100% audit of all resident rooms to ensure privacy curtains were in place on 03/17/2021. No other resident rooms identified with missing privacy curtains. No other residents were affected by the alleged deficient practice.</p> <p>Measures/Systemic Changes: The Housekeeping Manager educated all housekeeping staff on policy for cleaning cubicle curtains. This education discussed immediately having curtains on hand to replace dirty or torn curtain when removed. All education was completed on 3/23/21. Housekeeping staff out on leave, vacation, or PRN status will be educated prior to returning to their assignment by Housekeeping Manager. All licensed nursing staff and CNA's will be educated on notifying housekeeping of missing privacy curtains by 04/11/2021 SDC and/or designee. Nursing staff out on leave, vacation, or PRN status will be educated prior to returning to their assignment SDC and/or designee. Newly hired housekeeping and nursing staff will be educated during orientation by the Staff Development Coordinator and/or Housekeeping Manager.</p> <p>Monitoring: An audit tool was developed to monitor resident rooms for privacy curtains. These audits will be conducted by the Housekeeping Manager or his designee for 20 resident rooms three times a week for 4 weeks, then all resident rooms</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345226</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/18/2021</b>
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F 914	Continued From page 31	F 914	weekly for eight weeks. Continued audits will be determined based on results of prior months of audits. The results of these audits will be brought to the QAPI meeting by the Housekeeping Manager monthly for review and further recommendations.		