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	345138	A. BUILDING _____ B. WING _____	C 07/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR HEALTHCARE CENTER	322 NUWAY CIRCLE LENOIR, NC 28645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced onsite recertification and complaint investigation survey was conducted on 06/27/21 through 07/01/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# D68311.	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 06/27/21 to conduct a recertification and complaint survey and exited on 07/01/21. The credible allegation of compliance was validated on 07/09/21. Therefore, the exit date was changed to 07/09/21. Immediate Jeopardy was identified at: CFR 483.25 at tag F689 at a scope and severity of (J). The tags F689 (J) and F550 at a scope and severity of (H) constituted Substandard Quality of Care. Immediate Jeopardy began on 06/17/21 and was removed on 07/04/21. An extended survey was conducted.	F 000		
F 550 SS=H	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	F 550		8/13/21

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

Electronically Signed | 07/31/2021

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F 550	Continued From page 1 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 resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §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. This REQUIREMENT is not met as evidenced by: Based on record review, observations and resident and staff interviews, the facility failed to provide incontinence care to 4 of 4 residents (Resident #5, Resident #66, Resident #36, and Resident #35) reviewed for incontinence. The residents expressed feelings of being upset, humiliated, being forgotten about and feeling like	F 550	This plan of correction constitutes as written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged, or the correctness of the conclusions set for on	

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F 550	Continued From page 2 the staff members didn't care about them. The findings included: 1. Resident #5 was admitted to the facility on 3/31/21 with diagnoses that included chronic pain syndrome, heart failure and muscle weakness. The admission Minimum Data Set (MDS) assessment dated 4/5/21 indicated Resident #5 was cognitively intact, required extensive physical assistance with bed mobility, toilet use and personal hygiene. Resident #5 was always incontinent of both urine and bowel. Resident #5's care plan reviewed on 4/8/21 indicated Resident #5 required assistance for activities of daily living (ADL) related to chronic pain and generalized weakness. Interventions included to assist Resident #5 with ADL as needed and to assist with toileting or incontinence care routinely and as needed. An interview with Resident #5 on 6/27/21 at 9:49 AM revealed that she remembered having had to wait for hours before she was provided incontinence care. Resident #5 could not remember the dates when this had happened but said it had happened more than once on the day shift. On several occasions, she was changed at 6:00 AM prior to the night shift nurse aide (NA) leaving and then did not get checked again or changed until 2:30 PM. Resident #5 added there was one day when a NA entered her room to provide incontinence care to her roommate but when she requested to be changed as well, the NA told her that she was not assigned to her and that another NA was going to come and change her. But the NA that was assigned to her never	F 550	the statement of deficiencies. This plan of correction is prepared and submitted solely because of they requirement under state and federal law and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. 1. Resident #5 was provided incontinent care on 6/27 by NA #1, incontinent care was provided to resident # 66 on 6/29 by NA#4 and residents # 36 &35 were provided incontinent care by NA#1 on 6/28/2021. 2. An audit was conducted on 7/30/2021 of all incontinent residents to ensure incontinence care is being provided. This audit was completed by front line nurses. 3. Effective 7/29/2021, all Licensed Nurses, Certified Nursing Aides, and Nurse Aids in Training will be in-serviced by the Administrator on the policy and procedure for incontinence care. To include effective incontinent care, timely incontinence care and toileting assistance. All newly hired employees will receive the education in new hire orientation. No employee will be allowed to work without the education. Education to be completed by 8/4/2021. Effective 8/13/2021, The Director of Nursing or designee will conduct audits for incontinence care by observing 15 residents per week x 4 weeks, 10 residents per week x 4 weeks, then 5 residents per week x 4 weeks.	

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F 550	Continued From page 3 did come to provide incontinence care to her until the end of the shift. Resident #5 reported that this incident upset her and made her feel like she was forgotten about. An interview with Nurse Aide (NA) #1 on 6/29/21 at 10:11 AM revealed she often had to work on day shift on the hall where Resident #5 resided by herself and that it was impossible to get all her assigned tasks done. NA #1 stated it was possible that she was not always able to provide incontinence care to Resident #5 until around 2:30 PM on the day shift because the hall was full of residents who required incontinence care and it was harder to work with residents who required two-staff assistance for transfers. NA #1 also stated another NA on the next hall was supposed to help her out when she was by herself, but they didn't always come to help her, and they were probably busy with their own residents on the other hall. An interview with NA #2 on 6/29/21 at 3:35 PM revealed she was a restorative nurse aide, but she often got pulled to work on the hall. NA #2 stated she often had to work by herself on day shift on the hall where Resident #5 resided. NA #2 said it was very hard to get everything done when she had to work on the hall by herself and that it was possible that she hadn't been able to get to Resident #5 to provide incontinence care to her until the end of the shift. An interview with NA #3 on 6/29/21 at 4:04 PM revealed she usually worked on a different hall on the day shift but sometimes got assigned to watch the call lights on the hall where Resident #5 resided. NA #3 confirmed that she often had to answer Resident #5's call light towards the end	F 550	The Administrator will review the results of the weekly audit to ensure that incontinence care was provided. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Person Responsible: Director of Nursing	

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of the day shift and she sometimes found her wet with incontinence with her gown and bed sheet soaked with urine. NA #3 stated Resident #5 complained to her all the time that she didn't get changed for nearly eight hours.

An interview with the Director of Nursing (DON) on 7/1/21 at 8:53 AM revealed she had not been aware of the instances when Resident #5 was not provided incontinence care until the end of the day shift. The DON stated the NA assigned to the hall should have told her so she could get an extra NA to help on the hall. The DON stated the Activities Assistant and the Social Worker were both nurse aides and should have been able to help on the hall if needed. The DON added that Resident #5 should have been provided incontinence care in the morning before and after breakfast, before and after lunch and before the day shift staff members left. She said incontinence care being provided at least every two hours would have been great but was impossible if there was only one NA assigned to the hall. The DON confirmed that it was possible that a NA had refused to provide incontinence care to Resident #5 because she was not assigned to her but she should have helped her instead of making her wait for the NA that was assigned to her.

An interview with the Administrator on 7/1/21 at 12:50 PM revealed she had not been aware of any concerns related to Resident #5 not being provided incontinence care. The Administrator stated the restorative aides should have been available to help but if they got pulled to work on the hall, the NA on the next hall should have been helping the NA assigned to Resident #5. The Administrator stated incontinence care not being

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done timely was most likely due to not having enough staff to provide care to the residents in the facility.

2. Resident #66 was admitted to the facility on 5/24/21 with diagnoses that included diabetes, muscle weakness and chronic pain.

The Admission Minimum Data Set (MDS) assessment dated 5/31/21 indicated Resident #66 was cognitively intact, exhibited no rejection of care behaviors and required extensive physical assistance with bed mobility, toilet use and personal hygiene. He was also occasionally incontinent of both urine and bowel.

Resident #66's care plan dated 6/4/21 indicated Resident #66 required assistance for activities of daily living (ADL) related to generalized weakness and abnormalities of gait. Interventions included to assist with ADL as needed and to assist with toileting/incontinence care routinely and as needed.

An interview with Resident #66 on 6/27/21 at 9:25 AM revealed he had sat for three hours before he got provided incontinence care. Resident #66 stated this happened all the time on the evening shift. Resident #66 said one time, two separate nurse aides (NA) came into his room to turn his call light off twice on the evening shift and told him that they would come back but they never did come back. Resident #66 said on that evening, he was provided incontinence care at 1:00 AM. Resident #66 stated this incident upset him and that it made him feel like they didn't care about him. Resident #66 added that he had given up on using the bed pan because it took them a while to get back to him to take him off and being

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on a bed pan for an extended period hurt his back. He stated he usually had to wait for two to three hours on the evening shift before his call light was answered.

A second interview with Resident #66 on 6/30/21 at 9:29 AM revealed he was very frustrated and confused about the continued lack of response from the staff members especially on the evening shift. Resident #66 reported he had turned his call light on before 7:00 PM on 6/29/21 because he needed incontinence care, but nobody came into this room until 10:15 PM. Resident #66 stated Nurse Aide (NA) #4 went into his room at 10:15 PM and provided incontinence care to him but he never asked her why it took her a long time to come because he feared being retaliated on. Resident #66 stated he knew they were short-staffed. He further stated he felt like they had forgotten about him and that they didn't care about him.

An interview with NA #1 on 6/30/21 at 11:56 AM revealed she usually took care of Resident #66 on the day shift and he told her all the time that they don't answer his call light on the evening shift until after two to three hours.

An interview with NA #4 on 6/30/21 at 2:29 PM revealed she was usually assigned to Resident #66 on the evening shift but had to work by herself on the hall at least three times a week. NA #4 confirmed that she worked by herself on 6/29/21 on the evening shift and didn't get to Resident #66's call light until after 10:00 PM. NA #4 stated she could not remember seeing Resident #66's call light being on at 7:00 PM but said it was very busy during that time because the residents had just finished with supper and

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everyone was wanting either to go to the bathroom or to go to bed. NA #4 stated she usually started at the beginning of the hall and worked her way to the end of the hall so she could get everything done. She said that was why it took her so long to get to Resident #66's call light because he was one of the residents who were located all the way at the end of the hall. NA #4 further stated there was nobody to help her do her rounds because the other nurse aides had their own hall to take care of.

An interview with the Director of Nursing (DON) on 7/1/21 at 8:53 AM revealed she had not been aware of the instances when Resident #66 was not provided incontinence care until the end of the evening shift. She said incontinence care being provided at least every two hours would have been great but was impossible if there was only one NA assigned to the hall.

An interview with the Administrator on 7/1/21 at 12:50 PM revealed she had not been aware of any concerns related to Resident #66 not being provided incontinence care. The Administrator stated incontinence care not being done timely was most likely due to not having enough staff to provide care to the residents in the facility.

3. Resident #36 was admitted to the facility on 9/17/75 with diagnoses that included heart failure and cerebral palsy.

The Quarterly Minimum Data Set (MDS) assessment dated 4/23/21 indicated Resident #36 was severely cognitively impaired, required extensive physical assistance with bed mobility, toilet use and personal hygiene. Resident #36 was always incontinent of both urine and bowel.

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Resident #36's care plan reviewed on 4/21/21 indicated Resident #36 required assistance for activities of daily living (ADL) related to impaired mobility. Interventions included to assist Resident #36 with ADL as needed and to assist with toileting or incontinence care routinely and as needed.

An observation conducted on 6/28/21 at 2:40 PM of NA #1 providing incontinence care to Resident #36. When NA #1 placed the resident in the bed and began to change her there was an odor noted in the room, Resident #36 ' s brief was heavy with brown substance and urine. NA #1 had to change Resident #36"s pants and brief due to incontinence.

An interview with Nurse Aide (NA) #1 on 6/28/21 at 2:40 PM revealed she often had to work on day shift on the hall where Resident #36 resided by herself and that it was impossible to get all her assigned tasks done. NA #1 stated she had not provided incontinence care to Resident #36 during her 7:00 AM to 3:00 PM shift. She stated the last time Resident #36 had incontinence care was around 5:00 AM when third shift got the resident up from her bed. NA #1 stated the hall was full of residents who required incontinence care and it was harder to work with residents who required two-staff assistance for transfers. NA #1 also stated another NA on the next hall was supposed to help her out when she was by herself, but they didn't always come to help her, and they were probably busy with their own residents on the other hall.

An interview with the Director of Nursing (DON) on 7/1/21 at 8:53 AM revealed she had not been

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aware of the instances when Resident #36 was not provided incontinence care. The DON stated the NA assigned to the hall should have told her so she could get an extra NA to help on the hall. The DON stated the Activities Assistant and the Social Worker were both nurse aides and should have been able to help on the hall if needed. The DON added that Resident #36 should have been provided incontinence care in the morning before and after breakfast, before and after lunch and before the day shift staff members left. She said incontinence care being provided at least every two hours would have been great but was impossible if there was only one NA assigned to the hall.

An interview with the Administrator on 7/1/21 at 12:50 PM revealed she had not been aware of any concerns related to Resident #36 not being provided incontinence care. The Administrator stated the restorative aides should have been available to help but if they got pulled to work on the hall, the NA on the next hall should have been helping the NA assigned to Resident #36. The Administrator stated incontinence care not being done timely was most likely due to not having enough staff to provide care to the residents in the facility.

4. Resident #35 was admitted to the facility on 4/22/21 with diagnoses that included non-Alzheimer's dementia, respiratory failure and cerebrovascular accident (CVA).

The Admission Minimum Data Set (MDS) assessment dated 4/22/21 indicated Resident #35 was severely cognitively impaired, required extensive physical assistance with bed mobility, toilet use and personal hygiene. Resident #35

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was always incontinent of both urine and bowel.

Resident #35's care plan reviewed on 4/22/21 indicated Resident #35 required assistance for activities of daily living (ADL) related to impaired mobility. Interventions included to assist Resident #35 with ADL as needed and to assist with toileting or incontinence care routinely and as needed.

An observation conducted on 6/28/21 at 2:05 PM revealed Resident #35 sitting in his wheelchair in the middle of the hall with his hands covering his groin area. Resident #35's pants were observed to be wet to his waist and mid thigh. He stated that he had been wet for a hour waiting on assistance from a staff member.

An observation was conducted on 6/28/21 at 2:25 PM with NA #1 of her providing incontinence care to Resident #35. A strong urine odor was noted when she assisted the resident from his wheelchair. Resident #35's pants, shirt, brief and wheelchair pad was heavily saturated with urine. Urine was noted to be sitting in Resident #35's wheelchair on his slick covered foam pad. When NA #1 laid Resident #35 in the bed to change him she then had to change the sheet he laid on due to it being wet from the resident.

An interview with Nurse Aide (NA) #1 on 6/28/21 at 2:30 PM revealed she often had to work on day shift on the hall where Resident #36 resided by herself and that it was impossible to get all her assigned tasks done. NA #1 stated she had provided incontinence care last to Resident #35 around 11:00 AM. The interview revealed she had noticed he was wet when she was picking up the lunch trays around 1:30 PM however had to

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assist another resident with incontinence care first due to them having an appointment. NA #1 stated the hall was full of residents who required incontinence care and it was harder to work with residents who required two-staff assistance for transfers. NA #1 also stated another NA on the next hall was supposed to help her out when she was by herself, but they didn't always come to help her, and they were probably busy with their own residents on the other hall.

An interview with the Director of Nursing (DON) on 7/1/21 at 8:53 AM revealed she had not been aware of the instances when Resident #35 was not provided incontinence care. The DON stated the NA assigned to the hall should have told her so she could get an extra NA to help on the hall. The DON stated the Activities Assistant and the Social Worker were both nurse aides and should have been able to help on the hall if needed. The DON added that Resident #35 should have been provided incontinence care in the morning before and after breakfast, before and after lunch and before the day shift staff members left. She said incontinence care being provided at least every two hours would have been great but was impossible if there was only one NA assigned to the hall.

An interview with the Administrator on 7/1/21 at 12:50 PM revealed she had not been aware of any concerns related to Resident #35 not being provided incontinence care. The Administrator stated the restorative aides should have been available to help but if they got pulled to work on the hall, the NA on the next hall should have been helping the NA assigned to Resident #35. The Administrator stated incontinence care not being done timely was most likely due to not having

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F 550	Continued From page 12 enough staff to provide care to the residents in the facility.	F 550		
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. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident and staff interviews, the facility failed to honor the residents' preferences regarding use of an	F 561	This plan of correction constitutes as written allegation of compliance. Preparation and submission of this plan of	8/13/21

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	345138	A. BUILDING _____ B. WING _____	C 07/09/2021

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F 561	Continued From page 13 electric bed, smoking, preferred number of showers per week and activity of choice for 4 of 4 residents (Resident #5, Resident #69, Resident #67 and Resident #2) reviewed for choices. The findings included: 1. Resident #5 was admitted to the facility on 3/31/21 with diagnoses that included chronic pain syndrome, muscle weakness and abnormalities of gait and mobility. The admission Minimum Data Set (MDS) assessment dated 4/5/21 indicated Resident #5 was cognitively intact but required extensive assistance with most activities of daily living including bed mobility and transfer. The MDS further indicated Resident #5 was currently working with PT (Physical Therapy) and OT (Occupational Therapy). An interview with Resident #5 on 6/27/21 at 9:49 AM revealed her main concern during her stay at the facility was about having a crank/mechanical bed instead of an electric bed that she could control. Resident #5 stated she wanted an electric bed so she could control the height of the bed and raise/lower her head or legs whenever she wanted to. Resident #5 added that she would be able to lower her bed and sit on the side so she could work on exercises taught to her during therapy if she had an electric bed. Resident #5 further stated she currently had to rely on staff members to crank her bed up whenever she wanted to and felt frustrated that she had to ask them to come to her room just because she wanted to get repositioned in the bed. Resident #5 reported that she had told several staff members about wanting an electric	F 561	correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged, or the correctness of the conclusions set for on the statement of deficiencies. This plan of correction is prepared and submitted solely because of they requirement under state and federal law and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. 1. The facility failed to honor the residents' preferences regarding use of an electric bed (#5), smoking (#69), preferred number of showers per week (#67), and activity of choice (#2) for 4 of 4 residents. A) Resident # 5 was provided an electric bed on 6/30/2021. B) Resident # 69 was taken out to smoke on 6/30/21 by a housekeeping staff member, the receptionist, and NA Davidson. C) Resident #67 was discharged home from the facility on 7/15/2021. D) Resident #2 was allowed to bring model care working supplies to facility on 7/10/2021. These supplies consisted of a folding table, kits and a locked toolbox that included spray paints, Exacto knifes and model car glues. 2. A) The Social Worker conducted an audit of all cognitive resident who do not have an electric bed on 7/27/2021 to ensure there was not a request or desire for an electric bed to aide in their	

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F 561	Continued From page 14 bed but was told there was nothing they could do about it. An interview with Nurse Aide (NA) #1 on 6/29/21 at 10:11 AM revealed she usually worked with Resident #5 on day shift and she had complained to her several times that she wanted an electric bed. NA #1 reported that Resident #5 spent most of her time on her bed and only got up whenever she had visits from her family or when she had to work with therapy. An interview with Nurse #2 on 6/29/21 at 4:27 PM revealed Resident #5 had told her over a week and a half ago about wanting an electric bed which she could be able to adjust herself. Nurse #2 stated she told one of the housekeepers who said that they would check if any electric bed was available. An interview with the Social Worker (SW) on 6/30/21 at 9:12 AM revealed Resident #5 had been requesting for an electric bed ever since she was admitted to the facility. The SW stated she knew the Administrator had been trying to procure some electric beds but was not sure if any was currently available. The SW reported that housekeeping and maintenance usually kept up with the inventory of how many electric beds were used at the facility and how many were available. An interview with the Housekeeping Director (HD) on 6/30/21 at 9:49 AM revealed the facility had electric beds which were dispersed throughout the whole facility. She stated most beds on the rehabilitation hall were electric beds but could not say how many were currently available. The HD stated she was not aware of any request from	F 561	independence and found that 15 residents had a request for an electric bed. B) There are 3 other resident that may be affected by this deficient practice. Interviews were conducted with these residents by the Social Worker on 7/27/2021 to ensure they were being taken to smoke at the allotted times with no issues reported. C) All residents have the potential to be affected by the deficient practice; however, to ensure the facility can identify other that have the potential to be affected the Director of Nursing and/or designee conducted an audit on 8/6/2020 on all residents who are cognitively intact to ensure that the preference for the number of showers is documented in the care plan and assigned. For those residents who are not cognitively intact the Responsible Party, Power of Attorney or Guardian will be contacted. D) Interviews will be conducted with all cognitively intact residents to ensure that their activity preferences are being met. Interviews will also be conducted with the responsible party for all cognitively impaired residents to ensure their activity preferences are being met. Facility will attempt to reasonably accommodate resident activity preferences. This audit will be completed by 8/6/2021 by the Activities Director. 3. A) All staff to be educated by the	

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F 561	Continued From page 15 Resident #5 to get an electric bed and added that she would need to check the availability, but it would have to be approved first by the Administrator. An observation of the rehabilitation hall was made on 6/30/21 at 12:02 PM and revealed a total of 8 empty rooms with electric beds not being used on these rooms. An interview with the Administrator on 6/30/21 at 3:24 PM revealed the facility had a limited number of electric beds and more than half of the beds used in the facility were manual beds. The Administrator remembered Resident #5 requesting for an electric bed, but they didn't have one available at the time of her original request. The Administrator stated they usually reserved electric beds for the rehabilitation hall but some of the long-term care residents could use one if they were able to control it themselves. The Administrator admitted she hadn't thought about taking an electric bed from the rehabilitation hall because it had always been full until two to three weeks ago. 2. Resident #69 was admitted to the facility on 9/04/15 with diagnoses that included bipolar, depression and non- Alzheimer's dementia. The Quarterly Minimum Data Set (MDS) assessment dated 5/26/21 indicated Resident #69 was severely cognitively impaired, requiring extensive assistance with most activities of daily living including bed mobility and transfer. An interview with Resident #69 on 6/27/21 at 9:42 AM revealed her main concern was the staff not assisting her getting up to smoke at her smoking	F 561	Administrator and Director of Nursing regarding resident requests for electric beds and that these requests should be forwarded to the Director of Nursing and Administrator for review. All newly hired employees will receive the education in new hire orientation. No employee will be allowed to work without the education. Education to be completed by 8/4/2021. An audit will be conducted weekly by the Social Worker to ensure that resident's request for an electric bed hasn't changed for current residents and new admissions. This audit will be conducted weekly x 12 weeks. B) All staff were provided education by the Administrator and Director of Nursing regarding supervised smokers, their right to be up at allotted times to smoke and assisting them to the smoking area as needed. If needed the resident may be placed on the 11-7 get up list to ensure that they are gotten up timely for the morning smoking time. Also if a resident is out of the facility for an appointment or dialysis and miss the allotted smoking time, this resident will be allowed to smoke supervised outside of the allotted smoking time. Education to be completed by 8/4/2021. An audit will be conducted by the Social Worker of supervised smokers to ensure they are allowed to smoke during the allotted smoking times. This audit will be conducted 3x per week x 4 weeks, weekly x 4 weeks and every 2 weeks x 4 weeks.	

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F 561	Continued From page 16 times during the day which was 9:00 AM and 1:30 PM. During the interview Resident #69 was noted to be laying in bed. An interview with Resident #69 on 6/27/21 at 11:57 AM revealed the staff never assisted her up out of the bed to go outside during her supervised smoking time at 9:00 AM. She stated, "Please take me". An observation of Resident #69 on 6/28/21 at 9:03 AM revealed the resident to be laying in bed. Resident #69 stated, "nobody has gotten me up to go smoke". An interview with Resident #69 on 6/28/21 at 3:10 PM revealed she hadn't been taken outside during her supervised smoking times. She stated she wanted to go but nobody would take her. An interview with Nurse Aide (NA) #1 on 6/29/21 at 10:11 AM revealed she usually worked with Resident #69 on day shift and she had complained to her several times that she wanted to go outside and smoke. NA #1 stated she was the only NA on the hall and couldn't take the resident nor get her up prior to her smoking time of 9:00 AM. She stated with 13 complete lifts on the hall it was impossible to get everyone up and take a supervised smoker outside. An interview with the Housekeeping Director on 6/29/21 at 10:52 AM revealed that housekeepers were asked to take the supervised smokers outside during their smoking times. She stated Resident #69 was expected to roll herself in her wheelchair to the smoking door and housekeeping would assist her outside since they were not supposed to touch the residents. The	F 561	C) All licensed staff and non-licensed line staff were provided education by the Director of Nursing and Administrator regarding residents having the right to have multiple showers a week if they desire and that staff should make every effort to accommodate these requests. These requests should be forwarded to the Director of Nursing and Administrator. Education to be completed by 8/4/2021. An audit of residents who requested more than 2 showers per week will be performed 3x weekly x 4 weeks, weekly x 4 weeks, then every two weeks x 4 weeks by the Director of Nursing, Unit Manager and/or the Administrator. These audits will be performed both by reviewing documentation and resident interviews. D) Activities Director was educated by Administrator on 8/2/2021 on providing resident with activities as requested and that facility will attempt to reasonably accommodate those requests. Education will also be provided to all staff regarding residents rights and choices by 8/4/2021. An audit will be conducted for both cognitively intact and impaired residents to ensure that their activities preferences are being met. This audit will be conducted by the Social Worker and consist of 15 residents per week x 4 weeks, 10 residents per week x 4 weeks, and 5 residents per week x 4 weeks. Administrator will review the results of the	

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F 561	Continued From page 17 interview revealed the housekeepers were not trained nor qualified to assisted the residents during their smoking times. She stated if Resident #69 wasn't at the door at her expected time then the housekeepers didn't go looking for her. An interview conducted with Housekeeper #1 on 6/29/21 at 11:08 AM revealed she had been asked to assist the residents who required supervised smoking which was Resident #69. She stated sometimes the NAs got busy and didn't have the resident up in her wheelchair therefore she couldn't assist her outside. Housekeeper #1 stated she did not take Resident #69 outside to smoke on the morning of 6/29/21 because she didn't think about it. She stated she asked Resident #69 if she wanted to go smoke on 6/28/21 and the resident stated she couldn't get out of bed by herself and there wasn't a NA to get her up. An interview with the Director of Nursing on 6/29/91 at 11:22 AM revealed the supervised smoker in the facility was Resident #69. She stated if staff hadn't gotten her up at her designated smoking times then she didn't go outside to smoke. The DON stated housekeeping should ask her if she wants to go smoke however, they would not be able to assist her out of the bed. She stated she related the issue to staffing since the NA on the hall did not have time to get the resident up and dressed prior to her smoking time. 3. Resident #67 was admitted to the facility on 5/26/21. A review of the admission Minimum Data Set (MDS) dated 6/2/21 indicated Resident #67 was	F 561	weekly audits to ensure that residents activity preferences are being met. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Person Responsible: Activities Director	

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cognitively intact and required extensive assistance with one person staff for bathing.

An interview with Resident #67 on 6/30/31 at 10:00 AM revealed she received showers on Monday and Thursdays but would like to have more. Resident #67 had requested multiple times to nursing staff that she would like more than two showers per week but was told by nurse aids that she could not have more showers because there was not enough staff. Resident #67 revealed she would like a shower at least four times a week because her hygiene was important to her.

An interview with Nurse Aid (NA) #10 on 6/30/21 at 4:15 PM revealed Resident #67 never refused showers but does not recall Resident #67 requesting extra showers. NA #10 further revealed she had observed other residents requesting more showers and staff telling residents they could not receive an extra shower due to being short staffed.

An interview with Nurse #4 on 6/30/21 at 4:30 PM revealed Resident #67 had revealed she wanted an extra shower day. Nurse #4 further revealed Resident #67 could not receive an extra shower because nurse aids were unable to get current residents showers done.

An interview with the Director of Nursing (DON) on 7/1/21 at 8:55 AM revealed she was aware that showers were not getting done as scheduled due to short staffing. The DON further revealed she had not heard Resident #67 requesting more showers, but if she had she would not be able to receive an extra shower due to shortage of staff.

An interview with the Administrator on 7/1/21 at

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12:55 PM revealed she does not recall Resident #67 requesting additional showers but stated it was not realistic for residents to receive more than the current showers scheduled due to short staffing. The Administrator further revealed she expected for residents to be able to receive additional showers when the facility had more staff available.

4. Resident #2 was admitted to the facility on 3/24/2021 with diagnoses of depression.

Resident #2 quarterly Minimum Data Set (MDS) dated 6/29/2021 revealed he was cognitively intact. He required limited assistance of one person for personal hygiene, bed mobility and toileting.

Review of Resident #2's medical record revealed he was interviewed on 3/31/2021 by the Activities Direction (AD #5). The interview disclosed that the resident had informed AD #5 of his request to have his model car kits as part of his daily activity.

A review of Resident #2's care plan dated 4/9/2021 revealed a goal to maintain a high level of leisure independence. Interventions included "offer and provide materials for independent leisure and assist as needed with leisure supplies".

Observation of Resident #2 on 6/27/2021 at 11:00 AM revealed him sitting on the side of the bed, putting on his socks.

An interview with Resident #2 on 6/27/2021 at 11:10 AM revealed "there is nothing really for me to do here. I just want to work on my model cars". The resident recalled telling the Administrator on

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admission that he needed to work on his model cars to "keep from getting down." He indicated he had informed the Administrator during that conversation that he had his supplies in a locked toolbox. He stated he understood the model glue produced toxic fumes and he would have to have a ventilated area to work. He stated other residents could be at risk of injury if exposed to the glue fumes and the knife he used for trimming the plastic on the models. He specified the locked toolbox would keep everyone safe. He revealed his understanding that the toolbox would have to be kept in a secure area and not in his room. He indicated he had also made the Activities Director (AD #5) aware of his personal choice to work on models. He revealed AD #5 had provided a wooden block police car for him to put together, but "that was not the same." Resident #2 showed a new model car kit in a box in his drawer. He stated, "I've been ready to work on this, but they haven't given me my tools. My toolbox was at my dad's and they just had not told him it was okay to bring it."

An interview on 6/29/2021 at 9:00 AM with AD #5, revealed she was aware of Resident #2's request to work on his models. She stated she had added a "Working with Hands" activity to the calendar just for Resident #2. The activity involved putting together a wooden block car. AD #5 stated she had not received "the okay to do his models." AD #5 stated the issue had been discussed at department management meetings, but no further action had been taken.

Observation on 6/29/2021 at 9:15 AM of the activities calendar, activities room, and activity cart revealed coloring pages, puzzles, crafts, music, and exercise challenges. A computer

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F 561	Continued From page 21 programmed with games and music was also available. An interview with the facility Administrator on 6/30/2021 at 4:44 PM revealed she had spoken with Resident #2 and his father about the models. The Administrator stated Resident #2 could not be allowed to do the models "until we have deemed it safe." The Administrator acknowledged the issue had been discussed at department management meetings but could not provide a timeline during in which the facility could accommodate the resident's choice. The Administrator could not explain why the resident's request had not been resolved during his three-month residence.	F 561		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in	F 580		8/13/21

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F 580	Continued From page 22 §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and legal guardian interview the facility failed to notify the legal guardian when a resident eloped from the facility and a treatment center for 1 of 1 resident (Resident #49) reviewed for notification. The findings included: Resident #49 was admitted to the facility on	F 580	This plan of correction constitutes as written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged, or the correctness of the conclusions set for on the statement of deficiencies. This plan of correction is prepared and submitted	

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F 580	Continued From page 23 05/13/21 with multiple diagnosis which included bipolar disorder with mania and unspecified symptoms and signs with cognitive functions and awareness. Review of Resident court order revealed Resident #49 was ruled incompetent on 2/25/21 by the courts. The admission Minimum Data Set (MDS) dated 05/20/21 indicated Resident #49 was cognitively impaired. a. Review of Resident #49 progress notes revealed no notification was documented in contacting the guardian about the resident's elopement on 06/17/21. An interview with Nurse #3 on 06/30/21 at 12:15 PM revealed on 6/17/21 between 2nd and 3rd shift change Resident #49 eloped and left the facility. The nurse further revealed she did contact the Administrator but does not recall contacting Resident #49's legal guardian. An interview with the legal guardian on 06/28/21 at 8:20 PM revealed on 6/18/21 the guardian was contacted by the facility Social Worker (SW) that Resident #49 was making threats to leave the facility. The legal guardian further revealed she had no knowledge Resident #49 had eloped from the facility on the night of 6/17/21. An interview with the Social Worker (SW) on 06/29/21 at 11:35 AM revealed the SW had a conversation with Resident #49 Legal Guardian on 6/18/21 but did not reveal the resident had eloped the night of 6/17/21. An interview with the Administrator on 07/01/21 at	F 580	solely because of they requirement under state and federal law and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. 1. The facility failed to notify the legal guardian of Resident #49 when he eloped from the facility and treatment center. 2. An audit was of the nursing notes for the last 30 days to ensure that the responsible party and/or legal guardian was notified if a resident eloped from the facility or treatment center. Audit was conducted by Regional Nurse Consultant on 7/28/2021. No additional issues identified. 3. Administrator educated Director of Nursing and Social Worker on 7/30/2021 on the requirement to notify resident responsible party and/or legal regarding any changes that occur, such as a resident eloping from the facility or treatment center. All nursing staff were educated regarding notification of change policy by 8/4/2021. All newly hired employees will receive the education in new hire orientation. No employee will be allowed to work without the education. Education to be completed by 8/4/2021. An audit will be conducted by Director of Nursing of nursing notes to ensure that the responsible party and/or legal guardian was notified in the event of an elopement from the facility or treatment center. This audit will occur Mon-Friday in daily clinical meeting and will occur x 12 weeks.	

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F 580	Continued From page 24 12:55 PM revealed Resident #49 eloped from the facility on 06/17/21 and they did not notify the legal guardian. The Administrator further revealed the guardian should have been notified after Resident #49 eloped. b. Review of Resident #49 progress notes revealed no notification was documented in contacting the guardian about the Resident's elopement on 06/25/21. An interview with the legal guardian on 6/28/21 at 8:20 PM revealed the legal guardian had no knowledge Resident #49 had eloped from the dialysis center on 6/25/21. The Guardian stated Resident #49 was incompetent and could not make safe decisions for himself. An interview with the Social Worker (SW) on 6/29/21 at 11:35 AM revealed she was not made aware of Resident #49's elopement from the dialysis center on 6/25/21 and was never notified to contact the guardian. An interview with the Administrator on 7/01/21 at 12:55 PM revealed Resident #49 eloped from the facility on 6/25/21 from the dialysis center and did not notify the legal guardian. The Administrator further revealed the guardian should have been notified after Resident #49 eloped.	F 580	The Administrator will review the results of the weekly audits to ensure that the responsible party or legal guardian was notified in the event of an elopement from the facility or treatment center. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Person Responsible: Director of Nursing	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:	F 641		8/13/21

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F 641	Continued From page 25 Based on staff interviews and record review the facility failed to ensure the Minimum Data Set (MDS) was accurate for 1 of 1 resident reviewed for mood (Resident #49). The findings included: Resident #49 was admitted to the facility on 05/13/21 with multiple diagnosis which included bipolar disorder with mania and unspecified symptoms and signs with cognitive functions and awareness. Review of Resident court order revealed Resident #49 was ruled incompetent on 2/25/21 by the courts. The admission Minimum Data Set (MDS) dated 05/20/21 indicated Resident #49 required extensive assistance with one person assist with activities of daily living (ADL) and was not coded for delusions. An interview with Resident #49 on 06/27/21 at 10:23 AM revealed a week half ago he escaped the facility and made it to the fence line while smoking unsupervised in attempt to go home to another state and a staff member spotted him and brought him back inside the facility gate. Resident #49 revealed he also escaped again during dialysis recently while waiting on transport and made it down the road and a staff member stopped him. Resident #49 stated his plan was to panhandle to his home in another state to receive money to panhandle is way back to another state to live with friends that he has not spoken to in 20 years. Resident #49 stated he had no plans to seek medical treatment, continue dialysis, or where he would live or what he would eat during	F 641	1. The facility failed to ensure MDS was accurate for mood for Resident #49. Resident #49 MDS was modified on 7/29/2021. 2. Social Worker will review residents for mood to ensure the MDS is accurately coded. If discrepancies are found MDS are to modify assessments. This review will be completed by 8/6/2021. 3. Administrator will educate Social Worker and MDS Coordinator (as back-up) on completing MDS assessment accurately for mood. This education will be completed by 7/30/2021. MDS Coordinator will audit 5 MDS on to ensure assessment accurately coded for mood. This audit will be conducted weekly x 12 weeks. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Responsible Person: Administrator	

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F 641	Continued From page 26 his attempt to travel. An interview with the Social Worker (SW) on 06/30/21 at 9:10 AM revealed the SW completed the MDS assessing mood section of the MDS. The SW further revealed she did not code Resident #49 delusional because only progress notes were reviewed and there were no notes discussing delusional behaviors. The SW stated she did not review the admission information from the hospital nor discuss resident behaviors with direct care staff. The SW further revealed Resident #49's admission MDS was not coded accurately and the resident should have been coded for having delusions. An interview with the Director of Nursing (DON) on 07/01/21 at 9:15 AM revealed Resident #49 was extremely delusional and since admission had been discussing with staff that he was leaving the facility and panhandling his way from his home in another state to to another state. The DON stated Resident #40 should have been coded for delusions on the MDS. An interview with the Administrator on 07/01/21 at 12:55 PM revealed Resident #49 should have been assessed by reviewing his medical records, medicines, progress notes, interviewing direct care staff, and reviewing other assessments. The Administrator revealed Resident #49 should have been coded for delusions due to his diagnosis of bipolar disorder with mania and researching information needed to complete an MDS assessment accurately.	F 641		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677		8/13/21

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F 677	Continued From page 27 §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident and staff interviews, the facility failed to provide showers as scheduled to 7 of 14 residents (Resident #238, Resident #66, Resident #48, Resident #30, Resident #71, Resident #36, and Resident #60) reviewed for assistance with activities of daily living. The findings included: 1. Resident #238 was admitted to the facility on 5/20/21 with diagnoses that included diabetes with foot ulcer, muscle weakness and excoriation (skin-picking) disorder. The Admission Minimum Data Set (MDS) assessment dated 5/27/21 indicated Resident #238 was cognitively intact, exhibited no rejection of care behaviors, and required extensive assistance with personal hygiene and bathing. Resident #238's care plan dated 6/1/21 indicated Resident #238 required assistance with activities of daily living (ADL) related to generalized weakness, abnormalities of gait and diabetic foot ulcer. Interventions included to assist with ADL as needed and to assist with showers as scheduled on Monday and Thursday on day shift. A review of Resident #238's Bath Report Roster from 5/20/21 to 6/29/21 indicated she received a shower on 5/27/21, 6/3/21, 6/22/21 and a bed bath on 6/24/21.	F 677	This plan of correction constitutes as written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged, or the correctness of the conclusions set for on the statement of deficiencies. This plan of correction is prepared and submitted solely because of they requirement under state and federal law and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. 1. The facility failed to provide showers as schedule for residents #238,66,48,30,71,36 and 60. Showers for these residents were completed as follows #238 on 7/8, #66 on7/1, #48 on 7/16, #71 on7/9, #36 on 7/5, # 60 on 7/9 and #30 who was end of life expired on 7/3/21. 2. All residents have the potential to be affected by the deficient practice; however, to ensure the facility can identify other that have the potential to be affected the Director of Nursing and/or designee conducted an audit on 8/6/2020 on all residents who are cognitively intact to ensure that the preference for the number of showers is documented in the care plan and assigned. For those residents who	

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F 677	Continued From page 28 An observation and interview were conducted with Resident #238 on 6/27/21 at 11:48 AM. Resident #238 appeared disheveled with dried flakes noted on her hair and face. Her legs and arms were wrapped up with a cohesive elastic bandage. She stated that she did not have any open areas except for her right heel but her legs and arms were wrapped because she had a habit of scratching and picking at her skin. Resident #238 smelled of urine, but she was observed wearing regular cloth underwear. Resident #238 stated she last had a bed bath on 6/24/21 although she was supposed to receive a shower on Mondays and Thursdays on day shift. Resident #238 further stated she did not get her showers as scheduled because the staff members told her they did not have time to do them. On 6/24/21, Nurse Aide (NA) #3 gave her a bed bath instead of a shower because she had three other residents to give showers to and she didn't have time to give her a full shower. Resident #238 said she preferred a full shower instead of a bed bath because she didn't feel like she got cleaned enough with a bed bath. Resident #238 added she was able to use the bathroom with assistance from staff. An interview with Nurse Aide (NA) #1 on 6/29/21 at 10:11 AM revealed she worked with Resident #238 on day shift on 6/10/21, 6/14/21 and 6/17/21 but did not remember being able to give her a shower on those days because she didn't have time to do them. NA #1 stated she often had to work on the hall by herself and even though another nurse aide was assigned to help her, it was still hard to get all the showers done. NA #1 added she was unable to give Resident #238 a shower on 6/28/21 because she was the only	F 677	are not cognitively intact the Responsible Party, Power of Attorney or Guardian will be contacted. 3. All nursing staff will be educated regarding expectations that the residents shower/bed bath is completed on the designed day and the process if a resident refuses a shower/bed bath. Education completed by DON and/or ADON and will be complete by 8/4/2021. All newly hired employees will receive the education in new hire orientation. No employee will be allowed to work without the education. Education to be completed by 8/4/2021. Nurse managers will audit the weekly shower/bed bath schedules to ensure that residents are receiving a shower and/or bed bath as scheduled per their preference. This audit will consist of 15 residents per week x 4 weeks, 10 residents per week x 4 weeks and 5 residents per week x 4 weeks. Director of Nursing will review weekly audits to ensure shower/bed bath schedules to ensure that residents are receiving a shower and/or bed bath as scheduled and per their preference. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued	

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F 677	Continued From page 29 nurse aide on the hall, and she didn't have time to get any of the scheduled showers done. An interview with NA #5 on 6/29/21 at 3:16 PM revealed she worked with Resident #238 on 6/7/21 but did not remember giving her a shower that day. NA #5 stated they had too much to do on day shift and usually prioritized the residents who were supposed to get visits or who were going out to medical appointments. NA #5 said they didn't always have time to do showers on day shift. An interview with NA #3 on 6/29/21 at 4:04 PM revealed she had to give Resident #238 a bed bath instead of a full shower on 6/24/21 because she had three other residents who were scheduled to have a shower that day. NA #3 stated she just didn't have time to do all the showers that were scheduled for the day. An interview with the Director of Nursing (DON) on 7/1/21 at 8:53 AM revealed she was aware that the showers were not being completed as scheduled because of the facility's staffing issues. The DON stated they knew they did not have enough staff to provide care to the residents, but they just did not know how to fix the staffing issues. The DON added they had tried everything they could think of to hire more staff and ultimately, the goal was to hire a separate team of staff members to be assigned just to do the showers on their shift. An interview with the Administrator on 7/1/21 at 12:50 PM revealed she was familiar with Resident #238 and had seen her looking disheveled and her picking at her skin was significantly worse. The Administrator also stated	F 677	auditing is necessary to maintain compliance. 5. Person responsible: Director of Nursing	

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she knew Resident #238 sometimes had toileting accidents but refused to wear incontinent briefs. The Administrator said she couldn't say she expected showers to be done as scheduled because it was not realistic due to the staffing challenges the facility was currently facing.

2. Resident #66 was admitted to the facility on 5/24/21 with diagnoses that included diabetes, muscle weakness and chronic pain.

The Admission Minimum Data Set (MDS) assessment dated 5/31/21 indicated Resident #66 was cognitively intact, exhibited no rejection of care behaviors, was occasionally incontinent of both urine and bowel, and required extensive assistance with personal hygiene and bathing.

Resident #66's care plan dated 6/4/21 indicated Resident #66 required assistance with activities of daily living (ADL) related to generalized weakness, abnormalities of gait and chronic pain. Interventions included to assist with ADL as needed and to assist with showers as scheduled on Tuesday and Friday on day shift.

A review of Resident #66's Bath Report Roster from 5/24/21 to 6/29/21 indicated he received a shower on 6/1/21 and 6/22/21, and a bed bath on 5/28/21, 6/4/21 and 6/25/21. Resident #66 refused a shower on 6/15/21.

An observation and interview were conducted with Resident #66 on 6/27/21 at 11:13 AM. Resident #66 was lying in bed on a disposable draw sheet with an empty urinal on his bedside table. Resident #66 smelled of urine, but he stated he used his urinal whenever he had to urinate. Resident #66 stated since he had been

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in the facility, he had received only two showers and three bed baths. He said he was supposed to receive a shower on Tuesdays and Fridays on day shift but only received one when he requested for one. Resident #66 reported the nurse aides did not offer him a shower on the days he was scheduled to get one because the facility did not have enough staff. Resident #66 admitted he had refused one shower on 6/15/21 because it was too close to supper when they asked to take him to the shower room, and he didn't want to take a shower that late in the day.

An interview with Nurse Aide (NA) #1 on 6/29/21 at 10:11 AM revealed she worked with Resident #66 on day shift on 6/8/21 and 6/11/21 but did not remember being able to give him a shower on those days because she didn't have time to do them. NA #1 stated she often had to work on the hall by herself and even though another nurse aide was assigned to help her, it was still hard to get all the showers done.

An interview with NA #5 on 6/29/21 at 3:16 PM revealed she worked with Resident #66 on 6/8/21 but did not remember giving him a shower that day. NA #5 stated they had too much to do on day shift and usually prioritized the residents who were supposed to get visits or who were going out to medical appointments. NA #5 said they didn't always have time to do showers on day shift.

An interview with NA #2 on 6/29/21 at 3:40 PM revealed she was assigned to Resident #66 on 6/18/21 on day shift but did not have time to give him his scheduled shower because she was the only nurse aide on the hall.

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An interview with the Director of Nursing (DON) on 7/1/21 at 8:53 AM revealed she was aware that the showers were not being completed as scheduled because of the facility's staffing issues. The DON stated they knew they did not have enough staff to provide care to the residents, but they just did not know how to fix the staffing issues. The DON added they had tried everything they could think of to hire more staff and ultimately, the goal was to hire a separate team of staff members to be assigned just to do the showers on their shift.

An interview with the Administrator on 7/1/21 at 12:50 PM revealed Resident #66 had not been getting his scheduled showers due to the facility's staffing problems. The Administrator said she couldn't say she expected showers to be done as scheduled because it was not realistic due to the staffing challenges the facility was currently facing.

3. Resident #48 was admitted to the facility 05/07/21 and readmitted on 06/04/21 with diagnoses which included muscle weakness, pain, encephalopathy and heart disease.

The Admission Minimum Data Set (MDS) assessment dated 05/14/21 revealed she was severely cognitively impaired, exhibited no rejection of care behaviors, and required extensive to total assistance with all activities of daily living (ADL) including personal hygiene. According to the MDS Resident #48 had not had a bath or shower during the look back period.

Resident #48's care plan dated 06/15/21 indicated Resident #48 required assistance with activities of daily living (ADL) related to

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encephalopathy, pain and muscle weakness. Interventions included to assist with ADL as needed and to assist with showers on Wednesday and Saturday on day shift.

A review of Resident #48's Bath Report Roster dated 04/29/21 through 06/29/21 indicated she received a shower on 05/11/21, 05/14/21, 05/18/21, 05/26/21, 06/16/21 and 06/23/21. Resident #48 refused showers on 06/19/21 and 06/26/21.

An observation and interview were conducted with Resident #48 on 06/27/21 at 10:04 AM. Resident #48 was lying in bed on a disposable draw sheet. Resident #48 had particles in her teeth and her teeth appeared to have a filmy substance on them. Resident #48's fingernails were long and had brown debris under the nails. Resident #48's hair was disheveled and appeared not to have been combed. Resident #48 stated staff had not assisted her to brush her teeth and stated she had not had a shower. The resident further stated she preferred to have a shower over a bed bath. Resident #48 indicated she liked her fingernails long and did not want them cut but stated she wanted them cleaned.

An interview with NA #3 on 06/29/21 at 3:34 PM indicated she frequently worked on the 100 hall where Resident #48 resided and cared for her during the week. NA #3 revealed there was too much to do on day shift with 2 meals to serve and incontinence care to be done to get to showers. NA #3 further revealed she often worked alone on her hall and it was hard to get all the showers assigned done for the day. NA #3 said there were days when there was not even enough time to give residents assigned for showers a bed

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bath. NA #3 added they usually had to prioritize residents as to who looked like they needed a shower the worst or who was getting family visits to decide who might get a shower for the day.

A phone interview was attempted on 06/29/21 at 3:55 PM, 06/30/21 at 8:30 AM and 06/30/21 at 5:00 PM with an agency NA with no return calls.

An interview with the Director of Nursing (DON) on 7/1/21 at 8:53 AM revealed she was aware that the showers were not being completed as scheduled because of the facility's staffing issues. The DON stated they knew they did not have enough staff to provide care to the residents, but they just did not know how to fix the staffing issues. The DON added they had tried everything they could think of to hire more staff and ultimately, the goal was to hire a separate team of staff members to be assigned just to do the showers on their shift.

An interview with the Administrator on 7/1/21 at 12:50 PM revealed she was familiar with Resident #48 and had seen her looking disheveled and her dry skin. The Administrator also stated she knew Resident #48's family member wanted her showered at least 2 times per week and had requested she be up and dressed every day. The Administrator said she couldn't say she expected showers to be done as scheduled because it was not realistic due to the staffing challenges the facility was currently facing.

4. Resident #30 was admitted to the facility on 04/19/21 with diagnoses which included non-traumatic brain dysfunction, peripheral vascular disease (PVD) and dementia.

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The Admission Minimum Data Set (MDS) assessment dated 04/26/21 revealed Resident #30 was severely cognitively impaired, exhibited no rejection of care behaviors and required extensive assistance with personal hygiene. According to the MDS Resident #30 had not had a bath or shower during the look back period.

Resident #30's care plan dated 04/30/21 indicated Resident #30 required assistance with activities of daily living related to generalized weakness, lack of coordination, history of falls, abnormality of gait, cerebral ischemia and dementia. Interventions included to assist with ADL as needed and to assist with showers as scheduled on Wednesday and Saturday on evening shift.
A review of Resident #30's Bath Report Roster from 04/29/21 through 06/29/21 indicated she received a shower on 04/29/21, 05/07/21, 05/14/21, 06/17/21 and 06/26/21 and a complete bed bath on 06/23/21.

An observation of Resident #30 was conducted on 06/28/21 at 9:30 AM. Resident #30 was sitting in her wheelchair out in the hallway, dressed appropriately for the weather. Resident #30's hair was oily and disheveled, and her skin appeared dry and flakey. The resident was not able to be interviewed and unable to say when she last received a shower.

An interview with NA #4 on 06/29/21 at 5:56 AM revealed she typically worked on the 100 hall with Resident #30 on 2nd shift during the week. NA #4 stated there was usually just one NA on each hall on 2nd shift and they were just unable to get any showers done. NA #4 further stated it was all

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they could do to keep everyone changed and dried and fed their dinner. She indicated even when there was more than one NA on each hall that it was still difficult to get showers done.

A phone interview was attempted on 06/29/21 at 3:55 PM, 06/30/21 at 8:30 AM and 06/30/21 at 5:00 PM with an agency NA with no return calls.

An interview with the Director of Nursing (DON) on 7/1/21 at 8:53 AM revealed she was aware that the showers were not being completed as scheduled because of the facility's staffing issues. The DON stated they knew they did not have enough staff to provide care to the residents, but they just did not know how to fix the staffing issues. The DON added they had tried everything they could think of to hire more staff and ultimately, the goal was to hire a separate team of staff members to be assigned just to do the showers on their shift.

An interview with the Administrator on 7/1/21 at 12:50 PM revealed she was familiar with Resident #30 and had seen her looking disheveled and her skin being dry and flakey. The Administrator said she couldn't say she expected showers to be done as scheduled because it was not realistic due to the staffing challenges the facility was currently facing.

5. Resident #71 was admitted to the facility on 09/18/06 with diagnoses which included epilepsy, osteoporosis and dementia.

The Annual Minimum Data Set (MDS) assessment dated 05/28/21 indicated Resident #71 was severely cognitively impaired exhibited no rejection of care behaviors and required

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extensive with personal hygiene but was independent with bathing with set up. Resident #71's care plan dated 06/08/21 indicated Resident #71 required assistance with activities of daily living (ADL) related to intellectual disabilities, bipolar disorder, seizures, Parkinson's disease, chronic pain syndrome and dementia. Interventions included to assist with ADL as needed and to assist with showers as scheduled on Monday and Thursday on day shift.

A review of Resident #71's Bath Report Roster from 04/29/21 through 06/29/21 indicated he received a shower on 04/30/21, 05/07/21, 05/21/21, 05/28/21, 06/22/21 and 06/28/21.

An observation of Resident #71 on 06/30/21 at 10:34 AM revealed he was sitting up in his wheelchair in his room, dressed for the day. The resident appeared disheveled, had food particles in his teeth and dry flakey skin and was sitting in the dark in his room. The resident was not able to be interviewed and unable to say when he last received a shower.

An interview with NA #8 on 06/29/21 at 3:15 PM revealed she typically worked on the 400 hall where Resident #71 resided. NA #8 stated they typically worked with 1 NA to a hall and sometimes 2 and it was difficult to get incontinence care done for all the residents and showers were not always given as scheduled. NA #8 further stated they had to prioritize showers with who looked as though they needed a shower worse, who was going out for an appointment or who was getting a family visit. NA #8 said it was not fair to the residents, but it was the best they could do given the staff available to care for the residents and all that had to be done

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on day shift. NA #8 stated Administration was aware of how short they were working because they were always asking for staff to work over or come in early to cover the schedule.

An interview with the Director of Nursing (DON) on 7/1/21 at 8:53 AM revealed she was aware that the showers were not being completed as scheduled because of the facility's staffing issues. The DON stated they knew they did not have enough staff to provide care to the residents, but they just did not know how to fix the staffing issues. The DON added they had tried everything they could think of to hire more staff and ultimately, the goal was to hire a separate team of staff members to be assigned just to do the showers on their shift.

An interview with the Administrator on 7/1/21 at 12:50 PM revealed she was familiar with Resident #71 and had seen him looking disheveled. The Administrator also stated she knew Resident #71 liked to do things for himself but needed assistance. The Administrator said she couldn't say she expected showers to be done as scheduled because it was not realistic due to the staffing challenges the facility was currently facing.

6. Resident #36 was admitted to the facility on 9/17/75 with diagnoses that included heart failure and cerebral palsy.

The quarterly Minimum Data Set (MDS) assessment dated 4/23/21 indicated Resident #36 was severely cognitively impaired, exhibited no rejection of care behaviors and required extensive assistance with personal hygiene and bathing.

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Resident #36's care plan dated 4/21/21 indicated Resident #36 required assistance with activities of daily living (ADL) related to impaired mobility. Interventions included to assist with ADL as needed and to assist with showers as scheduled on Monday and Thursday on day shift.

A review of Resident #36's Bath Report Roster from 4/29/21 to 6/29/21 indicated she received a shower on 5/7/21, 5/10/21, 5/24/21, 6/4/21, 6/10/21, 6/21/21 and 6/22/21.

An observation was conducted of Resident #36 on 6/27/21 at 10:07 AM. Resident #36 appeared disheveled with a black substance underneath her fingernails.

An interview with Nurse Aide (NA) #1 on 6/29/21 at 10:11 AM revealed she worked with Resident #36 on day shift on 6/10/21, 6/14/21 and 6/17/21 but did not remember being able to give her a shower on those days because she didn't have time to do them. NA #1 stated she often had to work on the hall by herself and even though another nurse aide was assigned to help her, it was still hard to get all the showers done. NA #1 added she was unable to give Resident #36 a shower on 6/28/21 because she was the only nurse aide on the hall, and she didn't have time to get any of the scheduled showers done.

An interview with the Director of Nursing (DON) on 7/1/21 at 8:53 AM revealed she was aware that the showers were not being completed as scheduled because of the facility's staffing issues. The DON stated they knew they did not have enough staff to provide care to the residents, but they just did not know how to fix the staffing

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issues. The DON added they had tried everything they could think of to hire more staff and ultimately, the goal was to hire a separate team of staff members to be assigned just to do the showers on their shift.

7. Resident #60 was admitted to the facility on 11/25/2019 with diagnoses of stroke with hemiplegia (paralysis on one side of the body) and right-hand contracture.

Resident #60's quarterly Minimum Data Set (MDS) dated 5/20/2021 revealed he was cognitively intact. He required extensive assistance of one person for bathing and transfers

A review of Resident #60's care plan dated 10/2020 and last revised 6/2021 revealed no care plan focus for refusal of care. The care plan specified a goal of "resident will participate in activities of daily living". Interventions for the goal included allow/encourage resident to participate and encourage choices.

An interview with Resident #60 on 6/27/2021 at 10:30 AM revealed he preferred at least three showers a week, but he was not currently getting the two he was scheduled for. He stated he was scheduled for Tuesday and Friday showers, but he did not get his showers on his scheduled days due to low staffing. Resident #60 stated he often slept late into the day as that was his preference. He stated he thought staff often saw him asleep during the day and just wrote him down as refusing his shower. He stated, "I don't refuse showers. I can do most of it myself. I just need someone with me."

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F 677	Continued From page 41 A review of Resident #60's shower sheets revealed he was scheduled to have 2 showers per week. He was documented to have received 7 of the 16 scheduled showers from May to June 2021. The shower report did not show any shower refusals by Resident #60. An interview with Nurse Aide (NA) #1 on 6/29/2021 at 10:13 AM revealed she had been regularly assigned to the hall on which Resident #60 resided. NA #1 stated Resident #60 liked to have his showers in the evenings, but low staffing influenced the showers scheduled on first and second shift. An interview with the Director of Nursing (DON) on 7/1/2021 at 9:10 AM revealed she was aware that showers were not being given as scheduled. The DON stated low staffing was the root cause for Resident #60 not getting showers as scheduled. She stated a resident's refusal of a shower meant the resident verbally stated they did not want a shower. Refusal did not mean the resident was asleep when it was time for the shower, nor did it mean the Nurse Aide (NA) attempted only once. She stated her expectation of staff was that at least 2 attempts were made to provide a shower for residents. An interview with the facility Administrator on 7/1/2020 at 1:00 PM revealed she attributed missed showers to low staffing. The Administrator stated she expected staff to make sure showers were completed.	F 677		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		8/13/21

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F 689	Continued From page 42 §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, staff, Legal Guardian, Dialysis Nurse and Nurse Practitioner interviews the facility failed to prevent Resident #49's unauthorized and unsupervised exit from the facility. Resident #49 was ruled incompetent, had a legal guardian and had verbalized the desire to leave to several staff members. This affected 1 of 3 residents (Resident #49) reviewed for supervision to prevent accidents. Resident #49 was unsupervised and eloped from the facility's fenced in patio/smoking area the night of 6/17/21. The facility failed to communicate the 6/17/21 elopement to the dialysis center and Resident #49 was left unsupervised outside the dialysis center waiting on transportation on 6/25/21. As a result, Resident #49 eloped from the dialysis center and propelled himself two businesses down on a busy two-lane road. Resident #49 was found at a store by a dialysis center staff member and was taken back to the dialysis center. Immediate jeopardy began on 6/17/21 when Resident #49 exited the facility's fenced in smoking area unsupervised. The immediate jeopardy was removed on 7/4/21 when the facility provided and implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower	F 689	This plan of correction constitutes as written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged, or the correctness of the conclusions set for on the statement of deficiencies. This plan of correction is prepared and submitted solely because of they requirement under state and federal law and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. 1. Resident #1 was admitted to the facility on 5/13/21 with diagnosis of renal failure, bipolar disorder with mania, unspecified symptoms and signs with cognitive functions and awareness, muscle weakness, and vision impairment due to loss of right eye. Resident #1 was ruled incompetent on 2/25/2021 by the courts and was appointed a Legal Guardian with Phoenix Counseling Center at that time. On 6/17/2021, Resident #1 attempted to exit the facility front door stating that he was going back to West Virginia, facility Administrator was present. Later on, 6/17/2021 at approximately	

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F 689	Continued From page 43 scope and severity of 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 findings included: Review of Resident #49's court orders revealed on 02/25/21 Counseling Center received legal guardianship of Resident #49 and he was ruled incompetent by the courts. Guardianship included Resident #49 "needed assistance taking prescribed medications, communicate regarding health decisions, seek medical help for serious problems, keeping a sanitary living environment, to identify and void life-threatening behaviors, recognize and avoid hazards in home, seek help in emergencies, and capacity to make decisions without undue influence from others." Resident #49 was admitted to the facility on 05/13/21 with diagnoses that included renal failure, bipolar disorder with mania, muscle weakness, and vision impairment due to loss of right eye. A review of the Elopement Risk Evaluation for Resident #49 dated 5/14/21 revealed Resident #49 was marked for no concerns of elopement. The admission Minimum Data Set (MDS) assessment dated 5/20/21 indicated Resident #49 was assessed for being cognitively intact and requiring extensive assistance with one person staff for activities of daily living (ADL). The MDS further revealed Resident #49 mobilized with a wheelchair and was not coded for delusions or hallucinations.	F 689	11:00 pm, Resident #1 propelled himself through a gate in the fenced in smoking area. When Resident #1 exited the gate, the resident propelled himself behind the fence where the ground is unlevel and slopes to a drop off next to a wooded area. Another resident that was in the smoking area at the time of exit notified staff and staff went and returned Resident #1 back onto the facility. Facility did not complete an elopement assessment after either incident, implement safety interventions to address elopement or notify the Physician or Guardian. Additionally, resident receives dialysis services on Monday, Wednesday, and Friday. The facility did not communicate elopement risk to the dialysis center to ensure coordination of care for safety. On 6/ 25/21, dialysis notified the Van Driver when picking up Resident #1 that Resident #1 left the premises unassisted and propelled out of the parking lot down a busy side street to a gas station. A dialysis employee noted resident at the gas station and returned him to the dialysis center. The facility Van Driver communicated this information to the facility Administrator. The facility did not ensure safety interventions were initiated post incident on 6/25/2021 and did not notify the Physician or Guardian of the incident. On 6/29/2021 Resident#1 was assessed by Physician. Physician advised periodic safety checks, placement of a wanderguard related to elopement risk, and a Psychological Evaluation. Wanderguard placed on resident by	

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F 689	Continued From page 44 Resident #49 did not have a care plan for wandering or elopement behaviors. An interview with Resident #49 on 6/27/21 at 10:23 AM revealed a week half ago he "escaped" the facility and made it to the fence line while smoking unsupervised in attempt to go home to another state and a staff member spotted him and brought him back inside the facility gate. Resident #49 revealed he also "escaped" again during dialysis recently while waiting on transport and made it down the road and a staff member stopped him. A further interview with Resident #49 on 6/29/21 at 4:15 PM stated his plan was to panhandle from one state to another to live with friends that he has not spoken to in 20 years. Resident #49 stated he had no plans to seek medical treatment, continue dialysis, or where he would live or what he would eat during his attempt to travel. An interview with Nurse Aide (NA) #7 on 6/28/21 at 4:15 PM revealed on 6/17/21 at 11:30 PM Resident #49 was outside unsupervised smoking and another resident notified the NA that Resident #49 was outside of the fence. The NA #7 stated Resident #49 was sitting in his wheelchair outside the fence on the bank which sloped down to a wooded area. The NA further revealed she could barely see the resident due to the darkness and she ran and jumped the fence because she was scared the resident was going to flip off the bank. NA #7 stated Resident #49 plan was to travel to a store to buy cigarettes and go to another state. NA #7 stated a staff member contacted the Administrator and a note was put up at the nurse's desk instructing the staff if the	F 689	Licensed Nurse on 6/29/2021 and every 15-minute safety checks initiated. Smoking Assessment was completed on 6/29/2021 and Resident #1 was made a supervised smoker and with placement of wanderguard the door to the smoking area will alarm to alert staff of his proximity to the exit door. Elopement Assessment and care plan was updated by Director of Nursing on 6/29/2021 to reflect risk of elopement. All information was added to the Elopement Risk Binder and Careguide by the Administrator and Director of Nursing. Social Worker immediately contacted Community Mobile Crisis Unit for evaluation. Community mobile crisis completed an evaluation of Resident#1 on 6/29/2021 and recommends a higher level of care (i.e., secure unit). Social worker began referral process on 6/29/2021. On 6/30/2021, Social Worker, Minimum Data Set Nurse (MDS), Senior Clinical Consultant, and Regional Clinical Consultant conducted a care conference with resident #1□s legal guardian. Discussions included interventions for elopement risk, wanderguard and safety checks (15-minute checks), she agrees with plan of care as stated above. On 6/30/2021, the Administrator discussed with the Dialysis Center Social Worker the plan of care for Resident #1□s elopement risk which included interventions of calling facility when dialysis is completed, and Resident #1 will remain in the dialysis center until facility transportation arrives. Dialysis Social Worker confirmed understanding of the plan of care.	

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F 689	Continued From page 45 resident attempted to elope to contact the administrator and the police. The NA revealed no interventions or precautions were put into place during 2nd shift on 06/17/21. NA #7 recalled seeing the posted note during her 2nd shift for only two shifts. NA #7 stated that she was not made aware Resident #49 had spoken to staff about leaving the facility on 6/17/21. NA #7 further revealed Resident #49 had discussed leaving the facility to go to another state since his admission (5/13/21). An interview with Nurse #3 on 6/30/21 at 12:15 PM revealed on 6/17/21 during 2nd and 3rd shift change another resident reported to staff Resident #49 had left the facility fenced in Nurse #3 stated when she got to Resident #49, he indicated he was going to the store to buy cigarettes but was aware he had no money. He further revealed to Nurse #3 and NA #7 that he was going to the store to make money and travel to another state. Nurse #3 revealed the Administrator was contacted and a staff member posted a note at the desk if Resident #49 attempted to leave again to contact the Administrator and the police. Nurse #3 further revealed Resident #49 had never voiced leaving the facility prior to 6/17/21 and was not made aware of Resident #49 wanting to leave the day of 6/17/21. No interventions or precautions were put into place during Nurse #3's shift. Review of incident reports revealed there were no incidents documented for Resident #49 on 6/17/21. In addition, there was nothing documented in the nurses notes and an Elopement Risk Evaluation was not completed after he eloped on 6/17/21.	F 689	All residents that are at risk for elopement have the potential to be affected when policies and procedures for elopements are not followed. 2. Effective 6/29/2021, residents with Wanderguards were assessed to validate placement and function of the Wanderguards by Maintenance Director. Completion date of 6/29/2021. Effective 6/29/2021, elopement assessments and care plans were reviewed and validated for all current residents assessed at risk for elopement by the Director of Nursing and MDS Nurse. Elopement risk binders were reviewed and updated as needed by the Administrator. Completion date of 6/29/2021. Effective 7/1/2021, the Regional Nurse Consultant will review all electronic nursing notes and 24-hour log sheets for current residents for the last 14 days to ensure there are no unaddressed elopement risk behaviors. No other residents were noted to have elopement risks which were not addressed. This review was complete on 7/1/2021. Effective 7/2/2021, the Administrator, Regional Nurse Consultant, Rehab Manager, and the Environmental Services Manager began conducting interviews with all staff (to include contract staff) to determine if there were any other resident exhibiting behaviors for risk for elopement (i.e. stating they are wanting or going to leave, packing belongings, wandering, or exit seeking) to ensure there are no unaddressed elopement risk behaviors.	

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F 689	Continued From page 46 A review of the weather conditions per Weather Channel website revealed the following data for Lenoir, North Carolina. On 6/17/21 the website indicated it was partly cloudy with the low of 59 degrees Fahrenheit at 11:30 PM. An observation of the fenced in patio area was conducted on 6/28/21 at 4:55 PM and revealed residents entering and exiting the patio without having to use a code. The cement patio had covered area with one picnic table and was surrounded by a grass area. It was further observed the patio gate that Resident #49 exited out of had a metal latch and was closed with a yellow bungee cord. Outside of the gate a cement path wrapped around the left side of the building but to the right it was observed to be a small dirt path between the fence and the tree line which sloped down to a bank. An interview with the Maintenance Director on 6/29/21 at 10:40 AM revealed a request was completed by nursing staff dated 6/17/21 for a better gate mechanism. The Maintenance Director stated he was told to leave the bungee cord in place by the Administrator because it slows down residents trying to elope. An interview with Dialysis Nurse on 6/28/21 at 2:00 PM revealed Resident #49 was left unsupervised waiting on transportation at the front of the dialysis building on 6/25/21. Resident #49 left the parking lot and propelled himself down the side of a two-lane highway traveling past a restaurant and turning into a gas station that is at the intersection of a major highway. Resident #1 was spotted by a dialysis employee who revealed cars passing were having to go around the resident and the employee was able	F 689	Interviews completed 7/3/2021 with no further identified issues. 3. Effective 7/1/2021, Licensed Nurses were re-educated by the Administrator and Director of Nursing on Elopement assessments and completion. They are completed on admission, then quarterly and/or as needed by the Licensed Nurse. Any newly identified residents noted at risk will be communicated by the licensed nurse during shift huddle at the change of each shift. Education completed by 7/3/2021. Effective 7/1/2021, the Interdisciplinary Team (IDT) to include but not limited to Administrator, Director of Nursing, Charge Nurse, Activities Director, Social Worker, and Dietary Manager was re-educated by the Regional Clinical Consultant and Senior Clinical Consultant on Elopement Policy to include ensuring residents who are assessed at risk for elopement are supervised by facility staff and signs of elopement risk are recognized which included: resident packing belongings, resident stays near or searching for exit doors, and/or resident verbalizes/comments of wanting to go home. Additionally, they will be educated on their role in developing plans/interventions in response to any elopement risk. This should include a written careplan with elopement risk interventions formulated in conjunction with Physician/ Responsible Party (RP) and communicated with staff. Completed on 7/1/2021.	

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F 689	Continued From page 47 to get the resident back to the facility. The Dialysis Nurse revealed she told the facility transporter about what had happened. The Dialysis Nurse stated they had no knowledge of Resident #1 to elope from the facility, and if they have known they would have not allowed him to go outside unsupervised. The Dialysis Nurse further stated Resident #1 would no longer be allowed to sit outside to wait on transportation. An interview with the facility transporter on 06/28/21 at 1:00 PM revealed on 6/25/21 at 3:45 PM she picked up Resident #49 from the dialysis center on 6/25/21 and it was reported Resident #49 had left the facility unsupervised. The facility transporter further revealed Resident #49 made it two buildings down on a busy two-lane road. The Facility Transporter indicated Resident #49 had discussed multiple times escaping and leaving the facility and she had relayed the information to the Administrator. Review of incident reports revealed there were no incidents documented for Resident #49 on 6/25/21. In addition, there was nothing documented in the nurses notes and an Elopement Risk Evaluation was not completed after he eloped on 6/25/21. A review of the weather conditions per Weather Channel website revealed the following data for Lenoir, North Carolina on 6/25/21. The website indicated it was partly cloudy and 83 degrees Fahrenheit. An interview with the legal guardian on 6/28/21 at 8:20 PM revealed on 6/18/21 the guardian was contacted by the facility Social Worker (SW) and informed Resident #49 was making threats to	F 689	Effective 7/1/2021 □ Administrator, Director of Nursing, and/or Regional Clinical Consultant initiated education with all staff in all departments including contracted employees on the facility elopement policy including ensuring residents who are assessed at risk for elopement are supervised by facility staff. Facility ensures that residents that exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care. Facility will establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including assessment and identification of risk, evaluation and analysis of hazards and risk, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. Education also to include signs of elopement risk: resident begins packing belongings, resident stays near or searching for exit doors, and/or resident verbalizes/comments of wanting to go home. When the above behaviors are noted, the nurse must be notified immediately and the charge nurse. Notification to Physician/RP/Administrator and DON should occur immediately if resident displays these behaviors. Documentation of the behaviors should be documented in the Electronic Health Record as well as recorded on the 24-hour shift report. An elopement assessment should be completed by the	

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F 689	Continued From page 48 leave the facility, and the facility could not stop the resident. The guardian reported she was not informed he had eloped from the facility on the night of 6/17/21 and stated Resident #49 was incompetent and could not make safe decisions for himself. An interview with the Social Worker (SW) on 06/29/21 at 11:35 AM revealed on 6/17/21 the Administrator reported to the SW Resident #49 was wanting to leave the facility through the front door that morning and go to a store to panhandle money to be able to hitch hike to another state to get his money. The SW further revealed the SW had a conversation with the Legal Guardian on 6/18/21 but did not reveal the resident had eloped the night of 6/17/21. The SW indicated she told the guardian the resident was having behaviors of possible elopement stating he was going to leave the facility. The SW indicated no interventions were put in place to prevent the resident from eloping again after Resident #49 left the facility through the patio gate on 6/17/21. The Social Worker (SW) revealed she was not made aware of his elopement from the dialysis center on 6/25/21 and was never notified to contact the guardian. The SW stated no interventions were put in place to prevent the resident from eloping after leaving the dialysis center. The SW recalled conversations with the resident, and he did not understand why he had to be in the facility. A further interview with the SW on 7/1/21 at 8:15 AM revealed Resident #49 would not be able to be discharged to the community because the resident was unable to make safe decisions and was deemed incompetent. An interview with the Nurse Practitioner (NP) on	F 689	Licensed Nurse immediately following these behaviors. Elopement assessment will be reviewed, and appropriate intervention applied as needed. Interventions for elopement attempt: Redirect, diversional activities and notify Physician/RP and DON for further interventions. Residents identified at risk for elopement will be added to the Elopement Risk Binder, there are 2 Elopement Risk Binders in the facility (reception desk, nursing station). All staff re-educated on the location of the Elopement Binders. Each book contains current wander guard resident list and individual identification forms with pictures of these residents. Each hall nurse is responsible for checking placement of the wander guard each shift and ensuring it is documented in the medical record. Maintenance, Licensed Nurse or/designee will check function of all residents with wanderguards daily. Maintenance or designee will continue routine daily door and alarm checks to ensure alarms are functioning properly (ie sounds when activated). Additionally, Director of Nursing, Social Worker, Admissions Coordinator, Business Office Manager, Maintenance Director, Dietary Manager, Therapy Director and Licensed Nurses educated on the process of reviewing Resident Profile in the Electronic Health Record to determine who has a legal guardian due to competency status, this information will be entered by the Admissions Coordinator. Resident Profile will be printed off and placed in a binder at the nurse□s station for review by all staff	

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F 689	Continued From page 49 6/29/21 at 8:50 AM revealed Resident #49 was deemed incompetent before being admitted into the facility. The NP further revealed Resident #49 was incompetent, unable to make any kind of sound medical decisions, and had threatened to leave since 5/13/21. The NP further revealed she was made aware of Resident #49's first elopement on 6/18/21 but had not examined the resident. The NP revealed she was not made aware of Resident #49 leaving the dialysis center unsupervised on 6/25/21. An interview with the Director of Nursing (DON) on 6/29/21 at 9:25 AM revealed Resident #49 had stated to the Administrator on 6/17/21 that he was going to leave the facility because he was unhappy. The DON stated she did not recall if any interventions to prevent elopement were put in place for Resident #49. An interview with the Director of Nursing (DON) on 7/01/21 at 9:15 AM revealed Resident #49 was extremely delusional and had been since admission. The DON indicated she was not informed by the dialysis center or Administrator of Resident #49 leaving the dialysis center on 6/25/21 and did not recall any interventions put into place to address his elopement. The DON stated Resident #49 should not be discharged to the community because he was unable to make safe decisions for himself. An interview with the Administrator on 6/28/21 at 1:27 PM revealed on 6/17/21 during first shift Resident #49 was unhappy and continued to state he was going to leave the facility and go to another state. The Administrator revealed she had not put any interventions or precautions in place for Resident #49 at that time. She	F 689	as appropriate. The education will be communicated verbally and telephonically by the Administrator and the Director of Nursing. Written education will be available for review prior to the staff member working their assigned shift. Administrator will utilize a master employee list to track completion of education. No staff will be allowed to work until education is completed. This education will be included in orientation for New Hires. Completed by 7/3/2021. Effective 7/1/2021, Residents at risk for elopement that need to go out of the facility for an appointment will have elopement risk communicated with the receiving entity and have an appointment escort provided (i.e., family, facility staff). Nursing staff and Van Driver will be educated by Administrator. Monitoring will be completed daily Monday through Friday for all appointments to ensure escort is provided to residents at risk for elopement x 12 weeks. Effective 7/1/2021 Nursing Management to include Charge Nurse and/or Director of Nursing will review 24-hour report sheets and previous day nurses notes to identify any change in condition i.e., exit seeking behavior for appropriate follow up and notification to Physician review will be completed daily x 4 weeks then Monday □ Friday for 8 weeks. Any newly identified residents noted at risk will be communicated by the licensed nurse during shift huddle. Administrator will educate the Nursing Management team to include Charge Nurse, Licensed Nurses, Director of Nursing and Social Worker on	

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F 689	Continued From page 50 explained on 6/17/21 at 11:30 PM Resident #49 did exit out of the smoking area through the gate with plans of going to one state then to another. The Administrator stated she did not consider it an elopement because the resident was alert and had intact cognition. The Administrator further revealed if a resident with intact cognition left the facility and was alert it was not considered an elopement. The Administrator stated she had written a note and placed it at the nurses' desk for 24 hours on 6/18/21 for staff to keep an eye on Resident #49 and contact the Administrator and police if Resident #1 was to elope. The Administrator further revealed she did not discuss the resident's behaviors on 6/17/21 face to face with staff after he had discussed leaving the facility that day prior to the elopement. The Administrator stated no interventions or precautions were put in place. An interview with the Administrator on 06/29/21 at 12:15 PM revealed she was notified by the facility transporter on 6/25/21 of Resident #49 eloping from dialysis center but felt that it was the dialysis center's responsibility the resident eloped from their facility. The Administrator stated his elopement on 6/25/21 was discussed during their morning meeting on 06/28/21 and no safety interventions were put in place for Resident #49 to prevent further elopement. The Administrator revealed the facility should have made the dialysis center aware of Resident #49's behaviors of elopement but failed to do so. The Administrator further revealed she was aware Resident #49 was incompetent at admission and given the resident history of bipolar depression, and elopement, she should have sent Resident #49 to the hospital and put safety interventions in place after the first elopement on 6/17/21.	F 689	the new process of monitoring and responsibilities of this plan by 7/1/2021. Effective 7/1/2021 the Interdisciplinary Team (Nurse Managers, Social Work) will review residents at risk for elopement weekly in the Standards of Care Meeting to ensure continued appropriate interventions are in place to include Psych referral as indicated, with collaboration from the Physician/RP. Administrator will educate the Interdisciplinary Team on the new process of monitoring and responsibilities of this plan by 7/1/2021. Audit will be conducted weekly x 12 weeks. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Person Responsible: Administrator and Director of Nursing	

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The Administrator was informed of immediate jeopardy on 07/01/21 at 1:55 PM.

The facility provided the following acceptable IJ removal Plan with the correction date of 7/4/21:

The facility failed to supervise a cognitively impaired resident with wandering behaviors from exiting the facility and the dialysis center unsupervised.
What corrective action will be accomplished for the residents found to have been affected by the deficient practice?
1) Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:
Resident #49 was admitted to the facility on 5/13/21 with diagnosis of renal failure, bipolar disorder with mania, unspecified symptoms and signs with cognitive functions and awareness, muscle weakness, and vision impairment due to loss of right eye. Resident #49 was ruled incompetent on 2/25/2021 by the courts and was appointed a Legal Guardian with Phoenix Counseling Center at that time. On 6/17/2021, Resident #49 attempted to exit the facility front door stating that he was going back to West Virginia, facility Administrator was present. Later, 6/17/2021 at approximately 11:00 pm, Resident #49 propelled himself through a gate in the fenced in smoking area. When Resident #49 exited the gate, the resident propelled himself behind the fence where the ground is unlevel and slopes to a drop off next to a wooded area. Another resident that was in the smoking area at the time of exit notified staff and staff went and returned Resident #49 back onto the facility. Facility did not complete an elopement

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assessment after either incident, implement safety interventions to address elopement or notify the Physician or Guardian. Additionally, resident receives dialysis services on Monday, Wednesday, and Friday. The facility did not communicate elopement risk to the dialysis center to ensure coordination of care for safety. On 6/ 25/21, dialysis notified the Van Driver when picking up Resident #49 that Resident #49 left the premises unassisted and propelled out of the parking lot down a busy side street to a gas station. A dialysis employee noted resident at the gas station and returned him to the dialysis center. The facility Van Driver communicated this information to the facility Administrator. The facility did not ensure safety interventions were initiated post incident on 6/25/2021 and did not notify the Physician or Guardian of the incident.

On 6/29/2021 Resident #49 was assessed by Physician. Physician advised periodic safety checks, placement of a wander guard related to elopement risk, and a Psychological Evaluation. Wanderguard placed on resident by Licensed Nurse on 6/29/2021 and every 15-minute safety checks initiated. Smoking Assessment was completed on 6/29/2021 and Resident #49 was made a supervised smoker and with placement of wander guard the door to the smoking area will alarm to alert staff of his proximity to the exit door. Elopement Assessment and care plan was updated by Director of Nursing on 6/29/2021 to reflect risk of elopement. All information was added to the Elopement Risk Binder and Careguide by the Administrator and Director of Nursing. Social Worker immediately contacted Community Mobile Crisis Unit for evaluation. Community mobile crisis completed an evaluation of Resident#1 on 6/29/2021 and recommends a

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higher level of care (i.e., secure unit). Social worker began referral process on 6/29/2021. On 6/30/2021, Social Worker, Minimum Data Set Nurse (MDS), Senior Clinical Consultant, and Regional Clinical Consultant conducted a care conference with resident #49's legal guardian. Discussions included interventions for elopement risk, wanderguard and safety checks (15-minute checks), she agrees with plan of care as stated above. On 6/30/2021, the Administrator discussed with the Dialysis Center Social Worker the plan of care for Resident #49's elopement risk which included interventions of calling facility when dialysis is completed, and Resident #49 will remain in the dialysis center until facility transportation arrives. Dialysis Social Worker confirmed understanding of the plan of care.

All residents that are at risk for elopement have the potential to be affected when policies and procedures for elopements are not followed.

2) 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:

Effective 6/29/2021, residents with Wanderguards were assessed to validate placement and function of the Wanderguards by Maintenance Director. Completion date of 6/29/2021.

Effective 6/29/2021, elopement assessments and care plans were reviewed and validated for all current residents assessed at risk for elopement by the Director of Nursing and MDS Nurse. Elopement risk binders were reviewed and updated as needed by the Administrator. Completion date of 6/29/2021.

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Effective 7/1/2021, Licensed Nurses were re-educated by the Administrator and Director of Nursing on Elopement assessments and completion. They are completed on admission, then quarterly and/or as needed by the Licensed Nurse. Any newly identified residents noted at risk will be communicated by the licensed nurse during shift huddle at the change of each shift.

Effective 7/1/2021, the Interdisciplinary Team (IDT) to include but not limited to Administrator, Director of Nursing, Charge Nurse, Activities Director, Social Worker, and Dietary Manager was re-educated by the Regional Clinical Consultant and Senior Clinical Consultant on Elopement Policy to include ensuring residents who are assessed at risk for elopement are supervised by facility staff and signs of elopement risk are recognized which included: resident packing belongings, resident stays near or searching for exit doors, and/or resident verbalizes/comments of wanting to go home. Additionally, they will be educated on their role in developing plans/interventions in response to any elopement risk. This should include a written careplan with elopement risk interventions formulated in conjunction with Physician/ Responsible Party (RP) and communicated with staff.

Effective 7/1/2021 - Administrator, Director of Nursing, and/or Regional Clinical Consultant initiated education with all staff in all departments including contracted employees on the facility elopement policy including ensuring residents who are assessed at risk for elopement are supervised by facility staff. Facility ensures that residents that exhibit wandering behavior and/or

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are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care. Facility will establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including assessment and identification of risk, evaluation and analysis of hazards and risk, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. Education also to include signs of elopement risk: resident begins packing belongings, resident stays near or searching for exit doors, and/or resident verbalizes/comments of wanting to go home. When the above behaviors are noted, the nurse must be notified immediately and the charge nurse. Notification to Physician/RP/Administrator and DON should occur immediately if resident displays these behaviors. Documentation of the behaviors should be documented in the Electronic Health Record as well as recorded on the 24-hour shift report. An elopement assessment should be completed by the Licensed Nurse immediately following these behaviors. Elopement assessment will be reviewed, and appropriate intervention applied as needed. Interventions for elopement attempt: Redirect, diversional activities and notify Physician/RP and DON for further interventions. Residents identified at risk for elopement will be added to the Elopement Risk Binder, there are 2 Elopement Risk Binders in the facility (reception desk, nursing station). All staff re-educated on the location of the Elopement Binders. Each book contains current wander guard resident list and individual identification forms with pictures of these residents. Each hall nurse is responsible for checking placement of

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the wander guard each shift and ensuring it is documented in the medical record. Maintenance, Licensed Nurse or/designee will check function of all residents with wanderguards daily. Maintenance or designee will continue routine daily door and alarm checks to ensure alarms are functioning properly (ie sounds when activated). Additionally, Director of Nursing, Social Worker, Admissions Coordinator, Business Office Manager, Maintenance Director, Dietary Manager, Therapy Director and Licensed Nurses educated on the process of reviewing Resident Profile in the Electronic Health Record to determine who has a legal guardian due to competency status, this information will be entered by the Admissions Coordinator. Resident Profile will be printed off and placed in a binder at the nurse's station for review by all staff as appropriate. The education will be communicated verbally and telephonically by the Administrator and the Director of Nursing. Written education will be available for review prior to the staff member working their assigned shift. Administrator will utilize a master employee list to track completion of education. No staff will be allowed to work until education is completed. This education will be included in orientation for New Hires.

Effective 7/1/2021, the Regional Nurse Consultant will review all electronic nursing notes and 24-hour log sheets for current residents for the last 14 days to ensure there are no unaddressed elopement risk behaviors. No other residents were noted to have elopement risks which were not addressed. This review will be completed by 7/1/2021.

Effective 7/1/2021, Residents at risk for elopement that need to go out of the facility for an

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appointment will have elopement risk communicated with the receiving entity and have an appointment escort provided (i.e., family, facility staff). Nursing staff and Van Driver will be educated by Administrator.

Effective 7/1/2021 Nursing Management to include Charge Nurse and/or Director of Nursing will review 24-hour report sheets and previous day nurses notes to identify any change in condition i.e., exit seeking behavior for appropriate follow up and notification to Physician review will be completed daily. Any newly identified residents noted at risk will be communicated by the licensed nurse during shift huddle. Administrator will educate the Nursing Management team to include Charge Nurse, Licensed Nurses, Director of Nursing and Social Worker on the new process of monitoring and responsibilities of this plan by 7/1/2021.

Effective 7/1/2021 the Interdisciplinary Team (Nurse Managers, Social Work) will review residents at risk for elopement weekly in the Standards of Care Meeting to ensure continued appropriate interventions are in place to include Psych referral as indicated, with collaboration from the Physician/RP. Administrator will educate the Interdisciplinary Team on the new process of monitoring and responsibilities of this plan by 7/1/2021.

Effective 7/2/2021, the Administrator, Regional Nurse Consultant, Rehab Manager, and the Environmental Services Manager began conducting interviews with all staff (to include contract staff) to determine if there were any other resident exhibiting behaviors for risk for elopement (i.e. stating they are wanting or going

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to leave, packing belongings, wandering, or exit seeking) to ensure there are no unaddressed elopement risk behaviors. Interviews to be completed by 7/3/2021.

Effective 7/1/2021, the Administrator and Director of Nursing will be ultimately responsible to ensure implementation of this immediate jeopardy removal for this alleged noncompliance.

The facility alleged immediate jeopardy removal effective date 7/4/2021.

The credible allegation of compliance with an immediate jeopardy removal date of 7/4/21 was validated on 7/9/21. Elopement books were observed at the nurses' station and at the front reception desk. The elopement books included pictures and descriptions of residents currently identified at risk for elopement. Staff in-services conducted from 7/2/21 through 7/8/21 were reviewed. No staff were allowed to work until they had received the in-service education. In-services included the following: review of resident elopement risk profile, elopement policy review (missing resident/patient), an elopement drill, use of a post-elopement follow-up report, and an elopement drill or post-elopement checklist. Staff were further in-serviced on how to identify a resident at new risk for elopement. A review of the signature sheets for the in-services revealed all staff were educated.

Interviews with staff on 7/9/21 from 3:42 PM through 5:24 PM revealed staff indicated they were required to complete on-line education regarding wandering / elopement. Staff were able to describe location of elopement books, how to identify elopement behaviors, responses

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F 689	Continued From page 59 to wander-guard alarms, identity of the 4 current residents at risk for elopement, strict observation of resident smokers in outdoor patio. Nursing staff were able to verbalize timing of elopement risk assessments as being on admission, with any indication that a resident was planning to elope and following any elopement. The administrator and DON verbalized a daily check of 24-hour reports was completed at the morning meeting. The Maintenance Director provided a daily audit of magnetic door locks. The audit was reviewed with no concerns identified.	F 689		
F 725 SS=H	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides.	F 725		8/13/21

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F 725	Continued From page 60 §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews, the facility failed to provide sufficient nursing staff, resulting in missed showers for dependent residents (Resident #'s 238, 66, 48, 71, 30, 36, and 60), and incontinence care not being provided (Resident #'s 5, 66, 36 and 35) for 10 of 10 residents reviewed for staffing. The findings included: This tag is cross referred to: 1. F 550: Based on record review, observations and resident and staff interviews, the facility failed to provide incontinence care to 4 of 4 residents (Resident #5, Resident #66, Resident #36, and Resident #35) reviewed for incontinence. The residents expressed feelings of being upset, humiliated, being forgotten about and feeling like the staff members didn't care about them. 2. F 677: Based on record review, observations, resident and staff interviews, the facility failed to provide showers as scheduled to 7 of 14 residents (Resident #238, Resident #66, Resident #48, Resident #71, Resident #30, Resident #36, and Resident #60) reviewed for assistance with activities of daily living. An interview was conducted on 06/29/21 at 5:56 AM with NA #4 who revealed staffing was poor. NA #4 stated she was frequently asked to come	F 725	This plan of correction constitutes as written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged, or the correctness of the conclusions set for on the statement of deficiencies. This plan of correction is prepared and submitted solely because of they requirement under state and federal law and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. 1. Facility failed to provide sufficient nursing staffing, resulting in missed showers for dependent residents (Resident #□s 238,66,48,71,30,36 and 60) and incontinence care not being provided (Resident #□s 5,66,36, and 35). Resident #5 was provided incontinent care on 6/27 by NA #1, incontinent care was provided to resident # 66 on 6/29 by NA#4 and residents # 36 &35 were provided incontinent care by NA#1 on 6/28/2021. Showers for these residents were completed as follows #238 on 7/8, #66 on7/1, #48 on 7/16, #71 on7/9, #36 on 7/5, # 60 on 7/9 and #30 who was end of life expired on 7/3/21. 2. An audit was conducted of the last 14	

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F 725	Continued From page 61 in early and work 12 hour shifts and to work double shifts to cover the schedule. NA #4 further stated it was all they could do to complete 2 incontinence rounds on the residents. NA #4 said they were only able to get a few residents up early due to no assistance. An interview was conducted on 06/29/21 at 3:16 PM with NA #7 who revealed she was not able to get all assigned showers done as scheduled. NA #7 stated they were usually able to get 2 incontinence rounds done but there was no way to do 4 rounds on the residents. NA #7 further stated there was not time to get everyone up out of bed. An interview was conducted on 06/29/21 at 3:35 PM with NA #2 who revealed she was a restorative aide but had been working the halls all the time recently due to staffing. NA #2 stated she was only able to get 2 incontinence rounds done on residents and stated it was not possible to get the showers done as scheduled. NA #2 further stated she had not done restorative for months. An interview was conducted with the Administrator on 06/30/21 at 4:10 PM. The Administrator stated staffing was a bit of a challenge. She further stated they had done several things to assist with recruiting. The Administrator indicated she was currently doing the schedule and was in the process of trying to hire a Staff Development Coordinator (SDC) who would be responsible for doing the schedule once her orientation was completed. She further indicated they had increased the base pay for Nurse Aides twice in one year - once in November 2020 and again in May of 2021. The	F 725	days to ensure staffing was adequate for resident census. This audit was completed by 8/4/2021. 3. Regional Director of Operations educated the Administrator and Director of Nursing on the requirement to properly staff the facility based up on facility census. This education was completed by 8/4/2021. All nursing staff will be educated regarding expectations that the residents shower/bed bath is completed on the designed day and the process if a resident refuses a shower/bed bath. Education completed by DON and/or ADON and will be complete by 8/4/2021. Administrator and/or Director of Nursing will audit daily staffing schedules 5 x per week x 12 weeks to ensure staffing is adequate for resident census. Administrator and DON will conduct a daily labor meeting (Mon-Fri) as part of the morning meeting to ensure facility has adequate staffing for current census. Administrator will enlist the assistance from outside staffing agencies to supplement facility staff if needed. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	

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F 725	Continued From page 62 Administrator also said they had increased the sign on bonuses for Nurses, Medication Aides and Nurse Aides. The sign on bonuses were described as: Nurses - $3500.00, Medication Aides $2000.00. and Nurse Aides $1000.00 and referral for NAs $1500.00 and for Nurses $2500.00. The Administrator stated they were hiring some Patient Care Aides (PCAs) and were working under a waiver and sponsoring NAs through college and paying their tuition, books and malpractice insurance and pay $100.00 towards their testing in return for the NA agreeing to contract to work at the facility for at least one year after graduation. She further stated she had met with the Regional Director of Operations and was now allowed to refresh ads with recruiters and currently used 3 different agencies to provide Nurses and NAs but was not always able to secure staffing through the agencies. The Administrator indicated the problem with agencies was they were not always able to send staff to assist with resident care. According to the Administrator, she had implemented administrative staff coming in on the weekends to assist with serving meals and feeding residents and for screeners to assist with the process also. The Administrator described the following open positions: Nurses: 1 PT 1st shift LPN Medication Aides (MAs): 1 part time 1st shift MA and 1 part time 2nd shift MA Nurse Aides: 3 full time 1st shift, 5 part time or Baylor 3 to 4 full time 2nd shift or 3-4 part time or Baylor 2 full time 3rd shift and 2 part time She further described their current shift bonuses	F 725	5. Person Responsible: Administrator and Director of Nursing	

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F 725	Continued From page 63 for extra parts of shifts (4 hours) or whole shift (8 hours) as: NAs are offered $75.00 per shift up to $225.00 per shift and Nurses are offered $225.00 per shift. The Administrator said the hardest shift to cover for Nurses was the evening shift (3:00 PM to 11:00 PM) and for the NAs the hardest shift to cover was the night shift (11:00 PM to 7:00 AM). She further said the work ethic among young people was just not there anymore. The Administrator indicted she was currently offering a meal to staff when they had to work short and observed Nurses ' s week, Nurse Aide week and Nursing Home week, including a cook out and prizes. She further indicated they tried to find fun ways to honor the staff and boost their moral. A follow up interview was conducted on 07/01/21 at 1:22PM with the Administrator. She stated she didn ' t know how much more they could do other than what they were currently doing to improve staffing. The Administrator further stated she was working with the Regional Director of Operations on a weekly basis to try to resolve some of the staffing issues at the facility. She indicated the Regional Director of Operations was looking into other agencies to help with staffing and assisting with applications for employment.	F 725		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable	F 880		8/13/21

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diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, 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

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F 880	Continued From page 65 must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations and staff interviews, the facility failed to implement their infection control policies and the Centers for Disease Control and Prevention (CDC) guidelines for the use of Personal Protective Equipment (PPE) when 1 of 2 staff members (Nurse #1) failed to wear an N95 mask, eye protection, gown and gloves prior to entering the room of 1 of 1 resident (Resident #239) on enhanced droplet isolation. Nurse #1 also failed to disinfect a glucometer after use on 1 of 3 residents (Resident #9) reviewed for infection control. These failures occurred during a COVID-19 pandemic. The findings included: 1. The Centers for Disease Control and	F 880	This plan of correction constitutes as written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged, or the correctness of the conclusions set for on the statement of deficiencies. This plan of correction is prepared and submitted solely because of they requirement under state and federal law and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. 1. The facility failed to implement their infection control policies and the Centers for Disease Control and Prevention (CDC)	

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F 880	Continued From page 66 Prevention (CDC) guidance entitled, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic," updated on 2/23/21 indicated the following information regarding Personal Protective Equipment (PPE) use under the section, "Recommended infection prevention and control (IPC) practices when caring for a patient with suspected or confirmed SARS-CoV-2 infection": * Put on an N95 respirator (or equivalent or higher-level respirator) before entry into the patient room or care area. Disposable respirators should be removed and discarded after exiting the patient's room or care area and closing the door unless implementing extended use or re-use. * Put on eye protection (i.e., goggles or a face shield that covers the front and sides of the face) upon entry to the patient room or care area. Remove eye protection after leaving the patient room or care area, unless implementing extended use. * Put on clean, non-sterile gloves upon entry into the patient room or care area. Remove and discard gloves before leaving the patient room or care area, and immediately perform hand hygiene. * Put on a clean isolation gown upon entry into the patient room or care area. Remove and discard the gown in a dedicated container for waste or linen before leaving the patient room or care area. A review of the facility's COVID-19 policy entitled, "Personal Protective Equipment (PPE)," updated on 5/28/21 indicated the following information: * New Admission Area - HCP (Healthcare	F 880	guidelines for the use of Personal Protective Equipment (PPE) when Nurse #1 failed wear an N95 mask, eye protection, gown and gloves prior to entering room of Resident #239 on enhanced droplet precaution. Nurse #1 also failed to disinfect a glucometer after use for Resident #9. Nurse #1 was re-educated by the Director of Nursing and Executive Director on Transmission Based Precautions and the recommended Personal Protective Equipment of gown, gloves, eye protection, and N95 mask utilizing the facility policy on COVID-19 Response Guidelines to include recommendations of PPE for a resident on Enhanced Droplet Precautions in addition to signage. This education was provided on 6/27/21 and again on 7/29/21. Nurse #1 was re-educated by the Director of Nursing and the Executive Director on the facilities Policy for Cleaning/Disinfecting Glucometers. This education was provided on 6/27/21 and 7/29/2021. 2. All residents have the potential to be affected by this deficient practice. 3. A root cause analysis was completed by Director of Nursing, Infection Preventionist, Regional Nurse Consultant and QAPI (Quality Assurance Performance Improvement) Committee and Governing Body on 7/29/2021. This root cause analysis was incorporated into the facility intervention plan.	

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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 67 Personnel) should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a face shield that covers the front and sides of the face), gloves, and gown when caring for these residents. Resident #239 was admitted to the facility on 6/18/21 with diagnoses that included right hip joint replacement surgery. She received her first COVID-19 vaccine at the facility on 6/21/21. An observation was made of Nurse #1 on 6/27/21 at 12:59 PM entering Resident #239's room while wearing a surgical mask. A sign for enhanced droplet isolation was posted on Resident #239's door. The sign indicated the following instructions to follow before entering the room: N95 must fully cover the nose, mouth, and chin; eye protection when entering the room and gown and gloves when entering the room. There was also a storage bin for PPE right outside Resident #239's room. Nurse #1 carried a handful of towels and an ice pack into Resident #239's room without changing into an N95 mask and putting on a gown and gloves. She handed the towels and the ice pack to Resident #239 while talking to her. After 5 minutes, Nurse #1 exited Resident #239's room and rubbed hand sanitizer to both hands. Nurse #1 then walked over to 200 hall which was not a quarantine hall and started talking to Resident #36 who was in her wheelchair in the hallway. Nurse #1 applied a surgical mask onto Resident #36's face and pushed her wheelchair into her room. At 1:10 PM, Nurse #1 exited Resident #36's room and rubbed hand sanitizer to both hands. An interview with Nurse #1 on 6/27/21 at 1:17 PM	F 880	Beginning on 7/29/2021 completion date of 8/4/2021, all staff including any contract or agency staff were educated on recommended Personal Protective Equipment (PPE) for residents on Enhanced Droplet Precautions by the Director of Nursing and Executive Director. This education utilized the CDC video Utilizing PPE Correctly and the facility□s COVID-19 Response Guidelines to include recommended PPE for residents on Enhanced Droplet Precautions. Education was provided to staff through multiple avenues including but not limited to verbal, written and telephonically dependent on the staff members availability. Upon hire all staff will be educated by the Director of Nursing or her designee about Transmission Based Precautions and the recommended PPE for residents on Enhanced Droplet precautions beginning 8/2/2021. An attestation statement was completed by the Director of Nursing to attest education was completed on 8/4/2021. Beginning on 7/29/2021completion date of 8/4/2021, all Licensed nurses to be educated on the facility policy for cleaning and disinfecting resident glucometers. To include cleaning of individual resident dedicated glucometers and storage by the Director of Nursing and the Executive Director. After 8/4/2021, no staff will be allowed to work until education is completed. Administrative staff (Executive Director,	

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F 880	Continued From page 68 revealed that it was not relayed to her during report and she was not sure why Resident #239 was on enhanced droplet precautions, but she was responsible for Resident #239's care. Nurse #1 stated she thought the staff members only had to wear full PPE when providing direct patient care. Nurse #1 further stated she never wore an N95 mask, eye protection, gown and gloves if she entered Resident #239's room just to give her medications. Nurse #1 explained she went into Resident #239's room to give her an ice pack and some towels and she did not think she had to wear full PPE prior to entering the room just to do this task. An interview with the Director of Nursing (DON) on 6/27/21 at 1:30 PM revealed Resident #236 was on enhanced droplet isolation because she was admitted to the facility on 6/18/21 and she hadn't been fully vaccinated for COVID-19. The DON stated the staff members were expected to wear an N95 mask, eye protection, gown, and gloves prior to entering rooms on enhanced droplet isolation. The DON further stated that Nurse #1 should have worn an N95 mask, eye protection, gown and gloves prior to entering Resident #236's room. An interview with the Administrator on 7/1/21 at 12:50 PM revealed they have done various education regarding PPE use especially for residents on quarantine and could not explain why Nurse #1 failed to wear full PPE prior to entering a room on enhanced droplet precautions. 2. A review of the facility's policy entitled, "Cleaning and Disinfecting Glucometers," reviewed on April 2020 indicated the following	F 880	Director of Nursing, and Infection Preventionist) will monitor staff knowledge of Transmission based precautions and recommended PPE for Enhanced Droplet precautions by performing random staff interviews of 3 staff 3 times weekly x 6 weeks for a total of 9 staff then 4 staff weekly x 6 weeks. These interviews will be conducted across all shifts. Administrative staff (Executive Director, Director of Nursing, and Infection Preventionist) will conduct Personal Protective Equipment Audits to ensure Transmission Based Precautions are maintained by performing random observations of donning and doffing PPE across all shifts of 3 staff 3 times weekly x 6 weeks for a total of 9 staff then 4 staff weekly x 6 weeks Administrative staff (Executive Director, Director of Nursing, and Infection Preventionist) will complete observations of Licensed nurses performing cleaning and disinfecting of glucometers of 3 staff 3 times weekly x 6 weeks for a total of 9 staff then 4 staff weekly x 6 weeks 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	

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F 880	Continued From page 69 information: * Glucometers should be cleaned and disinfected after each use and according to manufacturer's instructions regardless of whether they are intended for single resident or multiple resident use. A review of the glucometer manufacturer's instructions dated 2015 indicated the following: * Clean and disinfect immediately after getting any blood on the meter or if meter is dirty. * If the meter is being operated by a second person who provides testing assistance, the meter and lancing device should be disinfected prior to use by the second person. An observation was made on 6/27/21 at 1:14 PM of Nurse #1 performing a blood sugar check on Resident #9. Nurse #1 cleaned the tip of Resident #9's right fifth finger with an alcohol wipe and stuck it with a lancet. Nurse #1 applied a drop of blood from Resident #9's right fifth finger into the glucometer strip that was inserted in a glucometer. Nurse #1 wiped the blood off Resident #9's right fifth finger and applied pressure until it stopped bleeding. After the blood sugar reading had registered on the glucometer, Nurse #1 pulled out the strip and discarded it, along with the alcohol wipe and her gloves. Nurse #1 proceeded to place the glucometer back into its case without disinfecting it and left the machine at the bedside. An interview with Nurse #1 on 6/27/21 at 1:17 PM revealed she only cleaned the glucometers at the end of the shift and that she didn't have to clean them anymore each time she used the glucometers because the residents had their own glucometers which were stored at the bedside.	F 880	5. Person Responsible: Administrator and Director of Nursing	

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F 880	Continued From page 70 An interview with the Director of Nursing (DON) on 7/1/21 at 9:45 AM revealed glucometers were supposed to be disinfected after each use even though they stored the glucometers at the bedside. An interview with the Administrator on 7/1/21 at 12:50 PM revealed she was not sure why Nurse #1 did not follow the facility's policy regarding glucometer disinfection because she had been educated on it.	F 880		
F 925 SS=E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to promote an environment free from crawling and flying insects. This was evident in 3 of 4 resident care hallways (200, 300, and 400 hallways) and ten of ten resident rooms (rooms 205, 308, 309, 311, 312, 313, 410, 411, 412 and 413). The findings included: On 06/27/21 at 10:07 AM a flying insect was observed in room 205 flying around Resident #36's head. On 06/28/21 at 12:30 PM a flying insect was observed in room 205 flying around Resident #36's head while she was eating her lunch.	F 925	This plan of correction constitutes as written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged, or the correctness of the conclusions set for on the statement of deficiencies. This plan of correction is prepared and submitted solely because of they requirement under state and federal law and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. 1. The facility failed to promote an environment free from crawling and flying insects. Pest control company was	8/13/21

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F 925	Continued From page 71 On 06/29/21 at 7:09 AM a flying insect was observed in room 205 flying around Resident #36's head. On 06/29/21 at 7:19 AM two crawling black insects were observed in the 400 hall. On 06/29/21 at 7:30 AM three crawling black insects were observed in the 300 hall. On 06/29/21 at 3:16 PM an interview was conducted with NA #7. NA #7 stated there were flying insects in room 205 and they had been there since the weather was warm. NA #7 further stated there were crawling small black insects in room 209 and she had seen them as recent as today and said they had been there at least a month or more. NA #7 stated she had placed it in the Maintenance Director's book, and he had sprayed but they just came back. On 06/29/21 at 3:35 PM an interview was conducted with NA #2. NA #2 stated she had seen crawling small black insects in room 209 as recent as today and they had been there for about a month. NA #2 stated she had told the Maintenance Director but had not placed it in the book and he had sprayed but they just came back over and over. On 06/29/21 at 3:34 PM an interview was conducted with NA #3. NA #3 stated she had seen crawling large black insects in the 300 and 400 hallways as recent as today and had seen crawling small black insects in rooms 311, 312 and 313 as recent as today. NA #3 stated there were always ants in the rooms on the 300 and 400 halls and stated the Maintenance Director was aware of it and just kept spraying for them,	F 925	contacted on 7/1/2021 and made an onsite visit to treat for crawling and flying insects on 7/2/2021. Fly management program was initiated, and fly lights were installed on each hallway, facility entrance and at patio exit on 7/14/2021. 2. An audit was conducted of all resident rooms and hallways to ensure there were no flying or crawling insects. This audit was conducted by the Maintenance Director by 8/2/21. Any issues were addressed immediately. 3. Administrator educated the Maintenance Director of the expectation that the facility remains free from crawling and flying insects and that the Maintenance Director is to call the pest control company between scheduled visits should the flying or crawling insects reappear. All staff were educated to report any signs of insects to the Maintenance Director or Administrator. Staff were also educated to encourage and assist residents from hoarding food items or dirty dinnerware, keeping unopened food items or spoiled foods in their rooms. Maintenance Director will conduct audits of resident rooms and hallways to ensure there are no flying or crawling insects. This audit be conducted weekly and will consist of 20 resident rooms/hallway x 4 weeks, 15 resident rooms/hallway x 4 weeks and 10 resident rooms/hallway x 4 weeks. Administrator will review the results of the	

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F 925	Continued From page 72 but they didn't go away. On 06/29/21 at 4:27 PM an interview was conducted with Nurse #2. Nurse #2 stated she had seen crawling large black insects in the 300 hall today and had seen crawling small black insects in rooms 311, 312 and 313 just today. Nurse #2 further stated she had seen flying insects in some of the patient rooms but none today. Nurse #2 indicated there were always ants in some of the rooms on the 300 hall and despite the Maintenance Director spraying for them they did not go away. Nurse #2 further indicated she and the NAs had repeatedly reported it to the Maintenance Director. On 06/30/21 at 10:45 AM an interview was conducted with the Maintenance Director. The Maintenance Director stated the facility had a contract with an insecticide company for monthly maintenance of insects and pests. According to the records provided, the last visit was on 06/02/21 and the facility had been sprayed inside and outside for insects and pests. In addition, the Maintenance Director explained he had sprayed for ants earlier today in room 410 and shared there were ants reported earlier in the week in rooms 411 and 412. The Maintenance Director indicated he was not aware of any flying insects in the building but was aware of ants being reported in room 309 specifically. The Maintenance Director further stated residents had reported seeing spiders in their rooms but stated the insecticide company had reported to him they did not have an insecticide spray to combat spiders. He indicated since the weather had been warm, he was having to spray more in between monthly visits from the insecticide company.	F 925	weekly audit to ensure the facility remains free from flying or crawling insects. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Person Responsible: Maintenance Director	

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F 925	Continued From page 73	F 925		

On 06/30/21 at 11:25 AM an interview was conducted with alert and oriented residents out in the smoking patio. Resident #67 stated she had "had ants in her bed" (room 413) and said staff had to change her bed linens twice in one day due to ants crawling in her bed. She further stated she could not remember the date but said it had been in the last month. Resident #52 stated there were ants and spiders in her room (room 309) and there had been a spider in her bedside table. Resident #52 stated they had sprayed but it did not seem to help. Resident #7 stated he had a problem with ants in his room and stated they sprayed but there were still ants. Resident #41 stated he had spiders in his room (room 308) and had killed a spider in the building as he was walking in from the smoking patio yesterday. Resident #7 stated he had a problem with ants in his room (room 411) and despite them spraying it was still a problem.

On 07/01/21 at 1:19 PM a follow up interview was conducted with the Maintenance Director. The Maintenance Director stated the facility had a contract with a pest control company for monthly maintenance. He did not have a copy of the contract with the insecticide company but stated the Administrator should have a copy on file. He stated in between the monthly visits from the pest control company he could spray insecticide, or they could put in a special request for a visit in between the monthly visits but had not done a special request. According to the Maintenance Director he was not aware there was a problem with crawling or flying insects today but stated he would spray the 300 and 400 halls and the rooms mentioned with insecticide. The Maintenance Director indicated he did not know where the

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flying insects were coming in but suspected it might be the door out to the smoking patio since the residents went out there in their wheelchairs and held the door open for a while. He further indicated there was a fan at the door to prevent flying insects from entering the facility but when the door is held open for an extended period the fan did not function as well.

On 07/01/21 at 1:22 PM an interview was conducted with the Administrator. The Administrator stated she could not locate a copy of the contract between the facility and the insecticide company but stated they had contacted them several times to get a copy of the contract. She indicated there had been complaints of ants, flies and spiders voiced by several residents and some staff since the warmer weather and said the Maintenance Director had sprayed but if that did not take care of the problem they would contact the company to come out again and spray. According to the Administrator the company comes out every month to spray to kill the insects, set traps for pests or whatever they needed, and they made additional trips out as needed and requested for issues.