STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 01/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	550 GLENWOOD DRIVE MOORESVILLE, NC 28115

(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 000	INITIAL COMMENTS A complaint investigation survey was conducted from 01/10/22 through 01/11/22 with an exit from the facility on 01/11/21. Additional information was obtained 01/14/22. Therefore, the exit date was changed to 01/14/22. There were (14) allegations investigated and (5) allegations were substantiated. See Event ID #8T6R11. 02/17/22- The 2567 was reposted due to a change in scope and severity of F 677.	F 000		
F 550 SS=G	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights.	F 550		2/14/22

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

Electronically Signed | 02/08/2022

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F 550	Continued From page 1 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 observations, record review, and facility staff and resident interviews, the facility failed to maintain resident's dignity by not providing incontinence care which made the resident feel miserable and embarrassed (Resident #1) and failing to assist a resident with toileting that resulted in the resident being incontinent of bowel making her feel embarrassed and ashamed (Resident #4) for 2 of 3 residents reviewed for dignity and respect. The findings included:dignity 1. Resident #1 was admitted to the facility on 8/11/2021. Review of the most recent comprehensive Minimum Data Set (MDS) dated 8/18/2021 revealed that Resident #1 was cognitively intact and required total assistance with bed mobility, transfers, toileting, and personal hygiene. Resident was always incontinent of both bladder	F 550	1) Resident #1 was assessed by Psychiatric Practitioner on 2/8/22to address feelings of being miserable and embarrassed as it relates to not having assistance with incontinence care with no negative findings. Resident #4 was assessed by Psychiatric Practitioner on 2/8/22 to address feelings of being embarrassed and ashamed as it relates to not having assistance with incontinence care during meals with no negative findings. 2) 100% audit of alert and oriented residents dependent on incontinence care were interviewed to ensure residents dignity is maintained by Nurse Manager on 2/4/22 with no negative findings. Body audit completed for non-oriented resident’s dependent on incontinence care on 2/4/22 by the treatment nurse with negative findings.	

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F 550	Continued From page 2 and bowel. Review of Resident #1's care plan dated 12/1/2021 revealed a focus area for bladder incontinence related to immobility. Interventions included providing peri care after each incontinent episode and checking resident #1 every two hours and assist with toileting as needed. An interview conducted with Resident #1 on 1/10/22 at 10:36 AM revealed that on 12/19/21 her brief was wet with urine and used call bell for assistance with incontinence care at 4:30 PM. Resident #1 stated at 4:30 PM Nurse Aide (NA)#1 entered the room, and informed Resident #1 that she would be right back. Resident #1 further stated that the NA #1 did not return until 10:10 PM. She was told by NA #1 that she had to wait because she was the only NA for the entire facility for the rest of the night. Resident #1 stated it made her feel miserable and embarrassed when she had to sit in a wet brief. The interview revealed she knew the exact times of the incident because she had been looking at the clock. An interview conducted with NA #1 on 1/10/22 at 3:26 PM revealed that she was the only NA assigned to the 100 hall and the 300 halls with over fifty (50) residents on 12/19/2021 during second shift. She stated that she was not able to perform every two (2) hour incontinence rounds. She further stated that Resident #1 had to wait more than three (3) hours to have incontinence care performed on 12/19/2021 during second shift. An interview conducted with Director of Nursing (DON) on 1/11/22 at 2:45 PM revealed it was expected for incontinence care to be completed	F 550	3) Reeducation of facility and agency nursing staff to include licensed nurses, certified medication aides and certified assistants will be completed on residents' rights to ensure dignity is being maintained during incontinence care to include incontinence care during meals by the Director of Nurses (DON)/ designee by 2/13/22. Nursing staff education on providing incontinence will also be provided on new hires during orientation. Facility and agency nursing staff will not be allowed to work until education is completed. 4) Activities Director to monitor 5 residents weekly for 4 weeks and monthly for 3 months to ensure residents dignity is maintained with incontinence care. Activities Director will report findings of the monitoring to the Interdisciplinary Team (IDT) during Quality Assurance Performance Improvement (QAPI) meetings monthly for three (3) months and will make changes to the plan as necessary to maintain compliance with maintain residents' dignity.	

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every two hours. She stated she was not aware Resident #1 had not been changed, and that she had to wait for over 3 hours for incontinence care on 12/19/2021. She further stated that she was not aware the NA was the only one working on 12/19/2021. The DON stated, " It was not acceptable for a resident to wait that long before being changed."

An interview conducted on 1/11/22 at 2:45 PM with the Administrator revealed he expected for nursing staff to be providing incontinence care as needed to the residents. The interview revealed staff were expected to not turn off a resident call light unless care had been provided.

2. Resident #4 was admitted on 07/22/2016 and recently readmitted to the facility on 12/07/21.

A review of Resident #4's quarterly Minimum Data Set Assessment dated 08/12/21 revealed her to be cognitively intact for daily decision making with no recorded instances of rejecting care. Resident #4 required extensive assistance with transfer, personal hygiene and was totally dependent on others for toilet use. Resident #4 was coded as always incontinent of bladder and frequently incontinent of bowel.

During an interview with Resident #4 on 01/04/22 at 10:21 AM, she stated this morning, she woke up and turned her call light on a little after 7:00 AM and needed to go to the bathroom. She explained no staff came into the room until around 8:15 AM after her breakfast had arrived. Resident #4 reported by that time, she had already had a bowel movement and was in the middle of eating her breakfast. She asked the

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F 550	Continued From page 4	F 550		

aide to return because she did not want to have to eat a cold breakfast. Resident #4 stated it was embarrassing and "very unpleasant" to have to eat breakfast with a dirty brief and felt ashamed. She reported she could recognize when she needed to have a bowel movement but could "hold it" for over an hour and she needed assistance getting in and out of bed and to the bathroom. Resident #4 reported was changed at 9:45 AM and knew this because she had looked at the clock in her room.

During an interview with Nurse Aide #2 on 01/10/22 at 2:43 PM she reported she was not on the schedule to work on first shift but had called the facility to see if they needed any additional help and was asked to come in. She reported when she arrived at the facility around 9:00 AM she noticed that Resident #4's call light was on. She reported when she went into the room, she told Resident #4 that she would return after breakfast since Resident #4's meal tray had already been served and she was in the middle of eating. Nurse Aide #2 reported Resident #4 was agreeable to that and stated she changed Resident #4 a little before 10:00 AM. She stated she did not know if anyone had checked on her prior to her arriving at the facility.

An interview with the Director of Nursing on 01/10/22 at 4:39 PM revealed there were 3 call outs that morning and that a resident should not have to wait from 7:00 AM to 10:00 AM before being assisted with toileting. The Director of Nursing reported if breakfast was being served or if the assigned nurse aide was otherwise indisposed, another staff member including nurses and other nurse aides, should make themselves available to provide incontinence care

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F 550	Continued From page 5 to resident who have had a bowel movement.	F 550		
F 565 SS=D	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility.	F 565		2/14/22

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F 565	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interview the facility failed to communicate the resident councils concerns with the nursing department, failed to respond to and provide resolution to grievances filed during the resident council meeting for 2 of 10 months of minutes reviewed (October 2021 and November 2021). The findings included: a. Review of the October 19, 2021 resident council minutes revealed that the council reported issues with staff talking on cell phones and listening to music while with the residents. There was no written response to the council's concerns. b. Review of the November 16, 2021 resident council minutes revealed that the council reported issues with nurses being on their cell phones while providing care. There was no written response to the council's concerns. The Director of Nursing (DON) was interviewed on 01/10/22 at 3:37 PM. The DON stated that she had recently had a staff meeting on December 12/01/21 and instructed the staff that personal cell phones should only be used in areas not around residents, used only in the break room, or outside. She stated that at times the Nurses may be talking to the providers and that may be why they were on their cell phones but stated the Nurse Aides (Na) would have no reason to talk on their cell phones during care. The DON stated she did not recall being made aware of the resident council's concerns of staff on cell phones prior the 12/01/21 staff meeting, or she would	F 565	1. Administrator and Activities Director reviewed resident council meeting minutes from October 2021 and November 2021 and provided resolution to grievances on 2/7/22. 2. Resident council meeting was held on 1/14/22 by Resident council President and Activities Director. Identified grievances found during the meeting were provided to each department on 1/15/22 and resolution was provided to resident council president and members on 2/8/22. Resolution provided was accepted by resident council members on 2/8/22. No negative findings were identified. 3. Re-education of the Resident Council Meeting Policy was conducted with Activities Director to include completing a resident council grievance log, providing Department Managers a copy of grievance forms and presenting resolution to resident council by Administrator on 2/7/22. Education will also be provided during orientation for new hires. Education was provided to Department Managers on providing resolution to grievances from resident council meeting on grievance forms with supporting documentation and returning findings to Activities Director by Administrator on 2/7/22. Education will also be provided during orientation for new hires. 4. Activities Director will monitor resident	

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F 565	Continued From page 7	F 565		

have addressed it before.

The Resident Council President was interview on 01/11/22 at 9:12 AM who confirmed that during October and November 2021 the resident council did report issues with staff being on cell phones. She stated she could not recall which resident complained and could not recall any follow up provided to the council about the issue.

The Activity Director (AD) was interviewed on 01/11/22 at 9:32 AM. The AD stated that one of the most frequent complaints that she heard during resident council meeting was the issue with staff talking on their cell phones while providing patient care. She explained that after the resident council meeting, she would write up the concerns and bring them to the morning meeting to discuss with the team. She added she would type a letter to each department manager and hand it out letting the department manager know of the concerns but that most of the time she did not receive any follow up from the department managers. She explained that she worked as manager on duty and saw lots of staff on cell phones and with ear buds in their ear and when she saw that she would always ask the staff member to please refrain from using their phones while in resident care cares. She added that she had reported the repeat concern from the council to the Administrator multiple times, but she did not see any improvement in the concern.

The Administrator was interviewed on 01/11/22 at 2:30 PM. The Administrator stated that when she first came to the facility in November 2021, she attended resident council and heard the resident complaints about staff being on their cell phones during care and in response to that they did an

council meeting grievance log to ensure grievances are logged, grievance resolution provided, and grievance resolution is presented to residents each month for 3 months to ensure grievance resolution is met. The Activities Director will report findings of the monitoring to the Interdisciplinary Team (IDT) during QAPI meetings monthly for three (3) months and will make changes to the plan as necessary to maintain compliance with communicating concerns to each department and providing resolution.

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F 565	Continued From page 8 education party where they had snacks and educated the staff about the resident's concern and then in December 2021, the council did not have any complaints, so she assumed the issue had been resolved. The Administrator stated that she had identified that there was a lack of response to the resident council concerns, so they had decided to revamp the whole process. She explained that they planned on having 2 meetings a month and all concerns being reviewed by her and each department manager would be notified of any concerns within their department. The Administrator added she expected timely follow up from those department managers to her about the issues so the issues could be resolved.	F 565		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F 584		2/14/22

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F 584	Continued From page 9 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and resident and staff interviews, the facility failed to have bath linens available for resident use on 4 of 4 halls. The Findings Included: Observations of the clean linen carts located on the 100, 200, and 300 halls and the clean linen closet on the 600 hall from 2:35 PM to 2:51 PM revealed the following: 100 hall linen cart had 5 hand towels, 0 washcloths, and 0 bath towels available for resident use 200 hall linen cart had 0 hand towels, 9 washcloths, and 4 bath towels available for resident use	F 584	1. Facility bath linen availability for 100, 200, 300, and 600 halls was reviewed on 1/12/22 by Regional Director of Operations. 2. Environmental Services Manager (EVS) and Regional Environmental Service manager audited facility linens using Periodic Automatic Replenishment (PAR) levels on to ensure adequate bath linens are available on each hall. 3. The Environmental Services Manager (EVS) was educated by the Regional Environmental Service Manager on ensuring bath linens are ordered and available at PAR levels on each hall on 1/13/22.	

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F 584	Continued From page 10 300 hall linen cart had 0 hand towels, 0 washcloths, and 5 bath towels available for resident use 600 hall linen closet had 0 hand towels, 5 washcloths, and 2 bath towels available for resident use Observations of resident rooms throughout the investigation revealed no stacked or hoarded linen located in the resident rooms. During an interview with Nurse Aide (NA) #1 on 01/10/22 at 2:39 PM revealed she "most definitely" felt there was an issue with having clean linen available for use. She reported she did not know if it was an issue with the amount of linen in the facility or if it was an issue with the laundry department getting clean linen back to the floor after it was washed. She stated there were times when she needed towels or washcloths and was unable to locate any clean linen on the hall. She stated when that happened, she had to stop providing care and go to the laundry room to see if they had any available. During an interview with NA #2 on 01/10/22 at 2:43 PM, she reported there was not enough linen available in the facility. She stated she did not know if it was an issue with the total amount of linen kept in the facility or if there was an issue with getting clean linen to the floor from the laundry room. She reported when she arrived for her shift this morning there was no clean linen on the hall she was assigned to and she had "to go chase after" clean linen so she could provide incontinence care to her residents. An interview with NA #3 on 01/10/22 at 3:18 PM,	F 584	Laundry staff to include agency laundry staff will also be educated by the EVS by 2/13/22 related to ensuring bath linen par levels are being maintained on each unit. Education will also be provided during orientation for new hires and agency staff. Laundry staff will not be allow to work until education is completed. Nursing staff will be educated by nurse managers/ designee on the location of additional linen and reporting concerns related to bath linen levels to the Administrator by 2/13/22. Education will also be provided during orientation for new hires and agency nursing staff. Nursing staff will not be able to work until education is provided. 4. EVS manager to monitor PAR levels weekly times 4 weeks and monthly times 3 months to ensure linen PAR levels are ordered and available for staff and residents. EVS manager to monitor 100, 200, 300, and 600 hall cart/storage for linen availability 5 times a week for 4 weeks and monthly for 3 months to ensure linen is available for staff and residents. The EVS manager will report findings of the monitoring to the Interdisciplinary Team (IDT) during QAPI meetings monthly for three (3) months and will make changes to the plan as necessary to maintain compliance with having bath linens available for residents to use	

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F 584	Continued From page 11	F 584		

revealed she did not believe there was enough linen kept at the facility. She reported she typically worked 2nd and 3rd shift and there were times when she had to use a pillowcase in lieu of washcloths to bathe and provide incontinence care to residents. She reported the laundry staff typically remained in the facility until 10:00 PM but from 10:00 PM - 5:00 AM there is no one in the facility to run laundry or bring it to the floor. She stated the facility often ran out of clean linens on 3rd shift when there was no laundry staff in the facility to wash it. She stated other nurse aides and herself have resorted to stockpiling and hiding clean linen when it comes to the floor because the limited amount of available clean linen.

During an interview with Laundry Aide #1 on 01/10/22 at 3:33 PM, she reported there have been issues with available linen in the facility recently. She reported there was a recent delivery of "a couple boxes of towels and washcloths" delivered after she complained there were only 13 towels and 8-9 washcloths cleaned out of 6 bins of laundry. Laundry Aide #1 also reported she was currently behind on getting clean linen to the floor due to a weekend laundry aide calling out sick on Saturday and Sunday. She reported due to the call out, no laundry was run on either day from 3:00 PM to 11:00 PM.

An interview with the Regional Environmental Services Director on 01/10/22 revealed she was unaware about any concerns regarding a lack of available linen. She stated she just completed a linen order for the facility the previous week when she ordered 240 bath towels and 1200 washcloths. She reported that order arrived at the facility last Friday. She reported she did believe

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THE CITADEL MOORESVILLE	550 GLENWOOD DRIVE MOORESVILLE, NC 28115

(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 584	Continued From page 12 there was a hoarding issue within the facility because "it's easier to place 20 towels and washcloths in a resident's room, instead of going back to the linen cart" when linen is needed. She stated unfortunately if a large amount of clean linen is found in a resident's room, it is not considered clean and is required to be returned to the laundry room and washed. She reported this resulted in a lot of "unnecessary work". An interview with the Administrator revealed it was expected that clean linen be available on the linen carts for use.	F 584		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems.	F 636		2/14/22

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F 636	Continued From page 13 (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and facility staff interviews, the facility failed to complete a	F 636	1) Identified resident #4 comprehensive Minimum Data Set assessment was	

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F 636	Continued From page 14 comprehensive Minimum Data Set Assessment within the required timeframe for 1 of 13 residents (Resident #4). The Findings Included: Resident #4 was admitted on 07/22/2016 and recently readmitted to the facility on 12/07/21. A review of Resident #4's Annual Minimum Data Set Assessment (MDS) dated 11/10/21 revealed it was not complete and had not been transmitted to the State Agency. An interview with MDS Nurse #1 on 01/10/21 revealed she had only worked in the building full time for a short while. She reported prior to working as the MDS Nurse in the building full time, she was assisting and helping "for a little bit". She stated she was aware there were a lot of late MDS Assessments within the system. She stated this was due to the facility not having a full time MDS nurse in the building for "some time". She stated she had planned to meet with the Corporate MDS Supervisor to come up with some type of game plan to try and get the past due MDS Assessments caught up. She stated the facility had brought in an agency MDS Nurse to assist her as well as trying to hire an additional MDS Nurse. She reported if she had to guess, there were more than 20 MDS Assessments that were late. During an interview with the Director of Nursing on 01/10/22 at 4:39 PM, she reported MDS Assessments should be completed timely and submitted within the regulatory timeframes.	F 636	completed by the Minimum Data Set (MDS) Nurse on 1/18/22. 2) Minimum Data Set Nurse completed an audit of Comprehensive Minimum Data Set assessments on 1/20/22. The identified missing Minimum Data Set assessments will be completed by 2/13/22. 3) Education was provided to MDS nurse and the Interdisciplinary Team on completing each section of the comprehensive Minimum Data Set according to the required timeframe on 1/10/22 by Regional Clinical Reimbursement Nurse. Newly hired Interdisciplinary team members, MDS nurses, and agency MDS nurses will also be educated during orientation and on hire. MDS nurses will not be allowed to work until education is completed. 4) MDS nurse to monitor at least 5 Comprehensive Minimum Data Sets assessments weekly times 4 weeks and monthly times 3 months to ensure they are completed timely. Minimum Data Set Nurse will report findings of the monitoring to the Interdisciplinary Team (IDT) during QAPI meetings monthly for three (3) months and will make changes to the plan as necessary to maintain compliance with completing comprehensive minimum data set assessments required.	
F 638 SS=E	Qrtly Assessment at Least Every 3 Months	F 638		2/14/22

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F 638	Continued From page 15 CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to complete a quarterly Minimum Data Set (MDS) assessment within 92 days of the previous quarterly MDS assessment for 1 of 4 residents reviewed (Resident #2). The findings included: 1. Resident #2 was admitted to the facility on 03/02/01. Review of Resident #2's medical record revealed a quarterly Minimum Data Set (MDS) assessment dated 06/09/21 had been completed. Further review of Resident #2's medical record revealed that there was a quarterly MDS assessment opened in the electronic system dated 12/05/21 but had not been completed and remained in progress. The MDS Coordinator was interviewed on 01/11/22 at 11:47 AM. The MDS Coordinator stated that was her first day as a full-time employee in the facility, she stated she helped at the facility off and on since September 2021. The two previous MDS Coordinator's had left and there had not been anyone in the MDS position for a period of time. The MDS Coordinator stated she was going to meet with her corporation and	F 638	1) Resident #2 quarterly Minimum Data Set assessment was completed by Minimum Data Set (MDS) Nurse on 1/16/22. 2) Minimum Data Set Nurse completed an audit of the current residents' quarterly Minimum Data Set assessments on 1/20/22 to ensure they are being completed within 92 days of the previous quarterly assessment. The identified missing Minimum Data Set assessments will be completed by 2/13/22. 3) Education was provided to the MDS nurse and the Interdisciplinary Team on completing each section of the quarterly Minimum Data Set within 92 days of the previous quarterly MDS assessment on 1/10/22 by Regional Clinical Reimbursement Nurse. Newly hired Interdisciplinary team members and MDS nurses will also be educated during orientation and on hire. The MDS nurses facility, agency nursing staff, and IDT team members will not be allowed to work until the education is completed. 4) MDS nurse to monitor at least 5	

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F 638	Continued From page 16 discuss a plan that would allow them to get caught up over the next three months. She indicated the facility was actively hiring because they should have two full-time MDS Coordinators. The MDS Coordinator stated she was not fully aware of how many late MDS there were, but she guessed approximately 20 that dated back to the end of November 2021 including Resident #2's quarterly MDS. The Administrator was interviewed on 01/11/22 at 2:30 PM with the Director of Nursing present. The Administrator stated that she had been at the facility since November 2021 and was aware that the facility had a long gap where they had no MDS Coordinator. She stated that the vacancy extended back to the summer of 2021 when both previous MDS Coordinators left and indicated that the facility had a travel MDS Coordinator that came to the facility about once a week and helped but during the holidays they got behind. She also added that it had taken them quite a while to hire a MDS Coordinator but added that they had put a performance improvement plan in place on 01/11/22 and the new MDS Coordinator along with corporate support would be working to get the late MDS assessments up to date. The Administrator stated that she expected the MDS to be completed timely and indicated that they were working towards that.	F 638	quarterly Minimum Data Sets weekly times 4 weeks and monthly times 3 months to ensure they are completed timely. Minimum Data Set Nurse will report findings of the monitoring to the Interdisciplinary Team (IDT) during QAPI meetings monthly for three (3) months and will make changes to the plan as necessary to maintain compliance with completing quarterly Minimum Data Sets assessments.	
F 640 SS=B	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for	F 640		2/14/22

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F 640	Continued From page 17	F 640		

each resident in the facility:
(i) Admission assessment.
(ii) Annual assessment updates.
(iii) Significant change in status assessments.
(iv) Quarterly review assessments.
(v) A subset of items upon a resident's transfer, reentry, discharge, and death.
(vi) Background (face-sheet) information, if there is no admission assessment.

§483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.

§483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:
(i)Admission assessment.
(ii) Annual assessment.
(iii) Significant change in status assessment.
(iv) Significant correction of prior full assessment.
(v) Significant correction of prior quarterly assessment.
(vi) Quarterly review.
(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.
(viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment.

§483.20(f)(4) Data format. The facility must

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F 640	Continued From page 18 transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete and transmit discharge assessments within 14 days of the assessment reference date for 2 of 4 sampled residents (Resident #1 and Resident #3). The findings included: 1. Resident #3 was admitted to the facility on 12/16/20. A review of Resident #3's quarterly Minimum Data Set (MDS) assessment dated 11/28/21 revealed the assessment had been completed. A further review of Resident #3's MDS assessments revealed three discharge assessments dated 12/01/21, 12/18/21 and 12/27/21 had not been completed and remained in progress. An interview was conducted with the MDS Coordinator on 01/11/22 at 11:47 AM. The MDS Coordinator explained that 01/11/22 was her first day as a full-time employee at the facility but she has helped the facility on and off since September 2021. She continued to explain that the two previous MDS coordinators had left and there had not been anyone in the MDS position for a while. The MDS Coordinator stated she did not know exactly how many late MDS assessments there were but estimated there were as many as twenty that dated back to	F 640	1) Resident #1 and Resident #3 discharge assessment was completed and transmitted on 1/11/22 by the Minimum Data Set (MDS) nurse. Resident #3 discharge assessment was completed and transmitted on 1/17/22 by the Minimum Data Set (MDS) nurse. 2) Minimum Data Set Nurse completed an audit of the residents' discharge Minimum Data Set assessments to ensure that they are being completed within 7 days and transmitted within 14 days after a facility completes the resident's assessment on 1/20/22 by the MDS nurse. The identified missing Minimum Data Set assessments will be completed by 2/13/22. 3) Education was provided to the MDS nurse and the Interdisciplinary Team on completing discharge assessments within 7 days and transmitting within 14 days after a facility completes the resident's assessment on 1/10/22 by Regional Clinical Reimbursement Nurse. Newly hired Interdisciplinary team members, MDS nurses, and agency MDS nurses will also be educated during orientation and on hire. IDT team member, facility and agency MDS will not be allowed to work until education is completed.	

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F 640	Continued From page 19 November 2021. The MDS Coordinator stated that she and the corporation had planned to meet and discuss a plan that would allow them to get caught up on the MDS situation in the next three months. She also indicated the facility was actively hiring because they should have two full-time MDS Coordinators. On 01/11/21 at 2:30 PM an interview was conducted with the Administrator with the Director of Nursing present. The Administrator, who had only been at the facility since mid-November 2021, explained that she was aware that there had been a long gap where the facility did not have an MDS Coordinator that extended back to the summer of 2021. The Administrator continued to explain that the two previous MDS Coordinators left and the facility utilized travel MDS Coordinators that came once a week but during the holidays they got behind. She also added that it had taken them quite a while to hire a MDS Coordinator. The Administrator stated on 01/11/22 they put a performance improvement plan in place and the new MDS Coordinator and the corporate support staff would be working to get the late MDS assessments caught up. The Administrator stated that she expected the MDS assessments to be completed timely and indicated that the facility was working toward that expectation. 2. Resident #1 was admitted to the facility on 08/11/2021. Review of Resident #1's medical record revealed a discharge Minimum Data Set (MDS) assessment dated 11/10/2021 and was completed on 1/11/2022.	F 640	4) MDS nurse to monitor at least 5 discharge Minimum Data Sets weekly times 4 weeks and monthly times 3 months to ensure they are completed within 7 days and transmitted within 14 days after facility completes the resident's assessment. Minimum Data Set Nurse will report findings of the monitoring to the Interdisciplinary Team (IDT) during QAPI meetings monthly for three (3) months and will make changes to the plan as necessary to maintain compliance with completing quarterly Minimum Data Sets assessments.	

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F 640	Continued From page 20 The MDS Coordinator was interviewed on 01/11/22 at 11:47 AM. She stated today was her first day as a full-time employee and explained Resident #1's discharge MDS assessment had been completed late. The Administrator was interviewed on 01/12/22 at 2:30 PM with the Director of Nursing present. The Administrator explained the facility had a long gap where they had no MDS Coordinator, and that she expected the MDS to be completed timely.	F 640		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the	F 656		2/14/22

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F 656	Continued From page 21 findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to develop a comprehensive care plan for a resident with a known history of wandering for 1 of 2 residents reviewed for accidents (Resident #5). Findings included: Resident #5 was admitted to the facility on 12/11/2021 with diagnoses that included Non-Alzheimer's dementia, and mild cognitive impairment. A nursing progress note dated 12/11/2021 at 3:58 PM revealed Resident #5 was alert and confused. A wanderguard (an electronic monitoring device) had been placed on his left ankle for elopement tendencies and exist seeking, looking for his truck. Review of a comprehensive Minimum Data Set	F 656	1) Resident #5 comprehensive care plan was reviewed and updated on 1/11/22 to including wandering into residents' room by the MDS nurse. On 1/12/22, Resident #5 was transferred to a memory care unit. 2) A review of the current facility wandering residents' comprehensive care plans was completed and updated on 2/4/22 by Minimum Data Set (MDS) Nurse. 3) Education was provided to the MDS nurse, Nurse Managers, and IDT team on identifying wandering residents and updating wandering care plans by the Administrator on 2/8/22. Newly hired Interdisciplinary team members, MDS nurses, nurse managers and agency MDS nurses will also be educated during	

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F 656	Continued From page 22 (MDS) dated 12/17/2021 indicated that Resident #5 was moderately impaired for daily decision making and required limited assistance with activities of daily living. The MDS further indicated that Resident #5 wandered 4 to 6 days during the assessment reference period that significantly intruded on the privacy of others. A behavior note dated 12/25/2021 at 6:37 AM revealed Resident #5 was extremely demented and confused, required step by step instructions and physical guidance to complete simple tasks, wandered in the hallways and had an extremely short memory. A nursing progress note dated 1/4/2022 at 6:14 AM revealed Resident #5 had been wandering in the hall off and on and staff had him sitting on a chair near the Nursing Station for monitoring. An observation on 1/10/2022 at 1:00 PM revealed Resident #5 ambulating up and down the hallways. Resident #5 was noted to have an ankle monitor to the left ankle. A review of the comprehensive plan of care dated 12/13/2021 did not include a care plan for Resident #5's wandering behaviors or ankle guard monitoring. An interview on 1/11/2022 at 9:30 AM with Nurse Aide (NA) #2 revealed she was aware Resident #5 was a known to wander. NA #2 verified Resident #5 wandered off his hall almost daily and staff from other areas of the building must bring him back his room. NA #2 further stated that Resident #5 wandered in and out of other resident rooms all the time.	F 656	orientation and on hire and will not be allowed to work until education is completed. 4) MDS nurse to complete monitoring of 5 wandering residents to ensure care plans have been completed, reviewed and updated weekly for 4 weeks and monthly for 3 months. The MDS nurse will report findings of the monitoring to the Interdisciplinary Team (IDT) during QAPI meetings monthly for three (3) months and will make changes to the plan as necessary to maintain compliance with developing care plans for residents with history of wandering.	

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F 656	Continued From page 23 An interview on 1/10/2022 at 10:00 AM with Nurse #1 revealed Resident #5 was a known to wander, wandered off the unit daily, and was often located on the other side of the facility by staff who worked those units. Nurse #1 stated Resident #5 wandered but he was not care planned for wandering. An interview on 1/11/2022 at 2:40 PM with the Director of Nursing (DON) revealed she was familiar with Resident #5 and his known history of wandering. She stated his comprehensive care plan should include wandering and ankle guard monitoring. She further stated that it was the responsibility of the MDS coordinator to implement Resident #5's care plan. An interview on 1/11/2022 at 2:48 PM with the Administrator revealed she was familiar with Resident #5's wandering and stated she expected all residents with known behaviors to include wandering to have a care plan that reflected interventions for wandering.	F 656		
F 677 SS=G	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §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, resident and staff interviews the facility failed to perform incontinence care for 2 of 3 dependent residents sampled for activities of daily living (Resident #1 and Resident #4).	F 677	1) Identified resident #1 and resident #4 were assessed for incontinent care needs on 1/10/22 by Administrator. 2) An audit of current residents who are dependent of continence care was	2/14/22

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F 677	Continued From page 24 The findings included: 1. Resident #1 was admitted to the facility on 8/11/2021 with diagnoses including hypertension, renal insufficiency and diabetes mellitus. Review of the most recent comprehensive Minimum Data Set (MDS) dated 8/18/2021 revealed that Resident #1 was cognitively intact and required total assistance with bed mobility, transfers, toileting, and personal hygiene. Resident was incontinent of both bladder and bowel. Review of Resident #1's care plan dated 12/1/2021 revealed a focus area for bladder incontinence related to immobility. Interventions included providing peri care after each incontinent episode and checking Resident #1 every two hours and assist with toileting as needed. An interview conducted with Resident #1 on 1/10/22 at 10:36 AM revealed that on 12/19/21 her brief was wet with urine and used call bell for assistance with incontinence care at 4:30 PM. Resident #1 stated at 4:30 PM Nurse Aide (NA)#1 entered the room, and informed Resident #1 that she would be right back. Resident #1 further stated that the NA #1 did not return until 10:10 PM. She was told by NA #1 that she had to wait because she was the only NA for the entire facility for the rest of the night. Resident #1 stated it made her feel miserable and embarrassed when she had to sit in a wet brief. The interview revealed she knew the exact times of the incident because she had been looking at the clock. An interview conducted with NA #1 on 1/10/22 at 3:26 PM revealed that she was the only NA	F 677	conducted on 2/3/22 by Nurse Managers with no negative findings. 3) The current facility and agency nursing staff to include licensed nurses, certified medication aides and certified nursing assistances will be educated by 2/13/22 on ensuring incontinence care is being provided per request and as needed per incontinence episodes by the Director of Nursing/ designee. Facility and agency nursing staff will be educated on hired and during orientation on ensuring incontinence care is provided. Staff will not be allowed to work until education is completed. 4) Nurse managers will monitor 5 residents weekly for 4 weeks and monthly for 3 months for incontinence care to ensure dependent residents are receiving incontinence care. Nurse managers will report findings of the monitoring to the Interdisciplinary Team (IDT) during QAPI meetings monthly for three (3) months and will make changes to the plan as necessary to maintain compliance with performing incontinence care to dependent residents	

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F 677	Continued From page 25	F 677		

assigned to the 100 hall and the 300 halls with over fifty (50) residents on 12/19/2021 during second shift. She stated that she was not able to perform every two (2) hour incontinence rounds. She stated that she answered the call light at 4:30 PM but was not able to perform incontinence care until approximately 4 hours later, and she confirmed Resident #1 was sitting in a brief soiled with urine.

An interview conducted with Director of Nursing (DON) on 1/11/22 at 2:45 PM revealed it was expected for incontinence care to be completed every two hours. She stated she was not aware Resident #1 had not been changed, and that she had to wait for over 3 hours for incontinence care on 12/19/2021. She further stated that she was not aware the NA was the only one working on 12/19/2021. The DON stated, it was not acceptable for a resident to wait that long before being changed.

An interview conducted on 1/11/22 at 2:45 PM with the Administrator revealed she expected for nursing staff to be providing incontinence care as needed to the residents. The interview revealed staff were expected to not turn off a resident call light unless care had been provided. She indicated that was unacceptable for Resident #1 to lay soiled for over 3 hours.

2. Resident #4 was admitted on 07/22/2016 and recently readmitted to the facility on 12/07/21 with diagnoses that included muscle weakness, lack of coordination, polyneuropathy, abnormal posture, and pain in unspecified joint.

A review of Resident #4's quarterly Minimum Data Set Assessment dated 08/12/21 revealed her to

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be cognitively intact for daily decision making with no recorded instances of rejecting care. Resident #4 required extensive assistance with transfer, personal hygiene and was totally dependent on others for toilet use. Resident #4 was coded as always incontinent of bladder and frequently incontinent of bowel.

A review of Resident #4's care plan dated 09/14/21 revealed a care plan area for: "The resident has an Activities of Daily Living (ADL) self-care performance deficit related to a decline in medical status". Interventions included: "the resident requires supervision to extensive assistance by staff for toileting."

During an interview with Resident #4 on 01/10/22 at 10:21 AM, she reported she had turned her call light on upon waking up this morning around 7:00 AM due to having to go to the bathroom for a bowel movement. She explained no staff came into the room until around 8:15 AM after her breakfast had arrived. Resident #4 reported by that time, she had already had a bowel movement and was in the middle of eating her breakfast. She asked the aide to return because she did not want to have to eat a cold breakfast. Resident #4 went on to explain she could recognize when she needed to have a bowel movement but could not "hold it" for over an hour and she needed assistance getting in and out of bed and to the bathroom. Resident #4 reported she was changed at 9:45 AM and knew this because she had looked at the clock in her room.

During an interview with Nurse Aide #2 on 01/10/22 at 2:43 PM she reported she was not originally scheduled to work but was asked to come in to fill a hole in the schedule after a call

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F 677	Continued From page 27 out. She reported when she arrived to the facility, she noticed Resident #4's call light was on. She reported when she entered the room, she noted Resident #4 was eating her breakfast. She asked if Resident #4 would like for her to return after her breakfast and Resident #4 reported she would. Nurse Aide #2 reported she returned to the room and provided incontinence care to Resident #4 a little before 10:00 AM. Nurse Aide #2 stated she did not know if anyone had seen Resident #4's call light or checked on her prior to her arriving to the facility. During an interview with the Director of Nursing on 01/10/22 at 4:39 PM, she verified there were multiple call outs this morning and that other staff were called in to fill the vacancies. The Director of Nursing reported no residents should have to wait 3 hours to be changed and that she expected call lights to be answered within 10-15 minutes.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility failed to follow physician orders for a treatment of a non-	F 684	1) Resident #3 non pressure wound was assessed on 1/12/22 by Wound Physician with the findings revealing improvement.	2/14/22

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F 684	Continued From page 28 pressure wound for 1 of 1 resident (Resident #3) reviewed for wound care. Findings included: Resident #3 was admitted to the facility on 1/4/2022. Her diagnoses included end stage renal disease, hypertension, diabetes, and atrial fibrillation. Review of a physician order written on 1/7/2022 revealed the physician had written the following order "Clean index finger on left hand with soap and water dry thoroughly, paint with betadine and cover with kerlix kling dressing, change daily." The order was transcribed to the treatment administration record (TAR). Review of treatment administration record (TAR) from 1/1/2022 through 1/31/2022 revealed the wound care order was not documented on 1/9/2022. An interview on 1/10/2022 at 10:36 AM with Resident #3 revealed the resident was readmitted back to the facility on 1/4/2022, resident stated that she had a wound on the index finger of the left hand. Resident #3 stated that she had no wound care done to her left hand on 1/9/2022. She stated that she had complained about this to the nurses, but no one had done any wound care. An interview on 1/10/2022 at 2:43 PM with Nurse #2 revealed that she was the nurse on call for the weekend of 1/8/2022 and 1/9/2022. She stated that she was called into work due to a nurse call out. She was the only nurse for over 37 residents on 1/9/2022 during first shift. She stated that she only performed a few treatments on 1/9/2022,	F 684	2) An audit of facility current residents with non-pressure wounds were assessed by Regional Consultant Nurse on 1/12/22 with no negative findings. 3) Education will be provided to the facility and agency licensed nurses on following physician orders for treatment of non-pressure wounds by 2/13/22 by the Director of Nursing/ designee. Facility and agency licensed nurses to be educated in orientation and upon hire. Licensed nurses will not be allowed to work until education completed. 4) Wound nurse to monitor non pressure wound treatments weekly for 4 weeks and monthly for 3 months to ensure physician orders for treatments are followed. Nurse managers will monitor 5 residents weekly for 4 weeks and monthly for 3 months for incontinence care to ensure dependent residents are receiving incontinence care. Nurse managers will report findings of the monitoring to the Interdisciplinary Team (IDT) during QAPI meetings monthly for three (3) months and will make changes to the plan as necessary to maintain compliance with following physicians' orders for treatment of non-pressure wounds	

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F 684	Continued From page 29 because it took her most of the day to administer medications. She confirmed she had not performed wound care for Resident #3 on 1/9/2022. An interview on 1/11/2022 at 10:47 AM with the Director of Nursing (DON) revealed she was unaware Resident #3 did not have any wound care performed on 1/9/2022. She further stated that it was her expectation for the staff to follow the physician orders. If wound care is ordered daily it should be performed daily. An interview was conducted on 1/11/2022 at 2:45 PM with the Administrator with the DON present during the interview. She stated that she had implemented a performance improvement plan (PIP) on 1/5/2022 related to staff not documenting when they perform wound care. She stated that she was unaware that Resident #3 did not have wound care performed on 1/9/2022. She further stated that it was her expectation for the staff to always follow the physician order. If wound care was ordered daily, she expected the staff to perform the wound care daily and document on the treatment administration record (TAR).	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.	F 689		2/14/22

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F 689	Continued From page 30 This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to provide supervision to prevent a cognitively impaired resident (Resident #5) from wandering into resident (Resident #6) room and sitting on her bed reviewed for privacy. This occurred for 1 of 1 sampled resident reviewed for accidents. The findings included: Resident #5 was admitted to the facility on 12/11/2021 with diagnoses that included Non-Alzheimer's dementia, bipolar disorder, mild cognitive impairment, and others. Review of a comprehensive Minimum Data Set (MDS) dated 12/17/2021 indicated that Resident #5 was moderately impaired for daily decision making and required limited assistance with activities of daily living. The MDS further indicated that Resident #5 wandered 4 to 6 days during the assessment reference period that significantly intruded on the privacy of others. Review of a care plan dated 1/11/2022 read, Resident #5 was an elopement risk/wanderer related to wandering. The goal read; Resident #5's safety will be maintained through the review date. The interventions included: check placement of function of safety alert every shift, distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, books, and walking with resident, and monitoring the location of the resident and documenting wandering behavior and attempted diversional interventions in the behavior log.	F 689	1. Resident #5 was transferred to Memory care unit on 1/12/22. Resident #6 was provided a stop sign for her door on 1/11/22. 2. Audit of the current cognitively impaired residents for supervision needs was completed on 1/22/22 by the Activities Director and MDS nurse. Identified residents were reviewed by the IDT team and their care plan was updated. 3. The facility and agency nursing staff to licensed nurses, certified medication aides and certified nursing assistants will be educated by 2/13/22 by the DON/ designee on identifying cognitively impaired resident who required supervision to include wandering residents and providing interventions to minimize risks to the identified resident and other residents. Facility nursing staff will be educated on hired. Facility and agency Nursing staff will not be allowed to work until education is completed. 4. Nurse managers to monitor identified residents who require staff supervision to include wandering residents to ensure safety measures remain in place weekly for 4 weeks and monthly for 3 months. Nurse managers will report findings of the monitoring to the Interdisciplinary Team (IDT) during QAPI meetings monthly for three (3) months and will make changes	

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F 689	Continued From page 31 An observation of Resident #5 was made on 1/10/2022 at 2:00 PM. Resident #5 had been up ambulating independently on the unit wandering in and out of other residents' rooms, the staff would redirect Resident #5 back to his room. Resident #6 was admitted to the facility on 1/4/2022 with diagnoses that included muscle weakness and lack of coordination and others. Review of the admission Minimum Data Set (MDS) dated 01/04/2022 revealed that Resident #6 was cognitively intact and required limited assistance with activities of daily living. An interview was conducted with Resident #6 on 1/10/2022 at 10:00 AM. Resident #6 stated that her only complaint of the facility was that Resident #5 "wanders into my room and the other night I woke up and he was standing over my bed looking at me." Resident #6 also stated, "It really scared me, I started screaming because I thought he was going to hurt me." She added that Resident #5 wanders all over the unit. Resident #6 stated that she reports this to the nurse every time Resident #5 comes into her room. She stated further stated "I do not want him coming into my room." An interview was conducted with Nurse Aide (NA) #2 on 01/10/2022 at 11:21 AM. NA #2 confirmed that she routinely worked the unit where Resident #5 and Resident #6 resided. She stated that Resident #5 did wander and could get a little aggressive at times. NA #5 stated that the staff tried to catch Resident #5 before he entered other residents' rooms but didn't always catch him in time.	F 689	to the president's plan of care as necessary to maintain compliance with providing supervision to prevent cognitively impaired residents from wandering into residents' rooms.	

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F 689	Continued From page 32 An interview was conducted with Nurse #1 on 1/10/2022 at 10:05 AM. Nurse #1 stated that she worked on the unit where Resident #5 and Resident #6 resided. She stated that Resident #5 was worse on night shift than he was on day shift. She stated that Resident #5 was not care planned for wandering, but that he did wander into other residents' rooms. An interview was conducted with the Administrator and Director of Nursing (DON) on 1/11/2022 at 2:50 PM. The DON stated Resident #5 does wander up and down the halls on the unit. She stated that the staff usually can redirect Resident #5 back to his room. The Administrator stated she would expect all the residents to have their privacy respected and if they wish for Resident #5 to not be in their room then we need to make that happen.	F 689		
F 725 SS=G	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with 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	F 725		2/14/22

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F 725	Continued From page 33 types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, and staff interview the facility failed to provide sufficient nursing staff that resulted in incontinence care not being provided for 2 of 3 residents (Resident #1 and Resident #4) and have sufficient staff to follow a physician order to perform daily wound care for 1 of 1 resident reviewed (Resident # 3). The facility also failed to have sufficient staff to complete a quarterly Minimum Data Set (MDS) assessment (Resident #2), a discharge assessment (Resident #1 and Resident #3) and a comprehensive Minimum Data Set Assessment within the required timeframe for 1 of 2 residents (Resident #4). In addition, the facility failed to develop a comprehensive care plan for a resident known to wander for 1 of 1 resident reviewed (Resident #5). Findings Included: This tag was cross referenced to: F677: Based on record review, resident and staff interviews the facility failed to perform	F 725	1) Resident #1 and Resident #4 incontinence care needs were reviewed by the Nurse Manager on 1/11/22. Resident #3 wound care regiment was reviewed by the wound care nurse on 1/12/22. Wound physician reviewed resident current treatment orders on 1/12/22 with no changes noted. Resident #2 quarterly assessment was completed on 1/16/22 by the MDS nurse which was newly hired on 1/10/22. Resident #1 and #3 discharge assessments completed on 1/11/22 by the MDS nurse. Resident #4 Comprehensive MDS completed on 1/17/22 by the MDS nurse. Resident #5 Comprehensive care plan for wandering completed on 1/11/22 by the MDS nurse. Additional Regional and agency support was provided on 1/11/22 to completed identified MDS assessments and updated wandering care plans.	

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F 725	Continued From page 34 incontinence care for a dependent resident for 2 of 3 residents sampled for activities of daily living (Resident #1 and Resident #4). F550: Based on observations, record review, and facility staff and resident interviews, the facility failed to maintain resident's dignity by not providing incontinence care which made the resident feel miserable and embarrassed (Resident #1) and failing to assist a resident with toileting that resulted in the resident being incontinent of bowel making her feel embarrassed and ashamed (Resident #4) for 2 of 3 residents reviewed for dignity and respect. F684: Based on observations, record review, resident and staff interviews, the facility failed to follow physicians' orders for a treatment of a non-pressure wound for 1 of 1 resident (Resident #3) reviewed for wound care. F636: Based on record review and facility staff interviews, the facility failed to complete a comprehensive Minimum Data Set Assessment within the required timeframe for 1 of 2 residents (Resident #4). F638: Based on record review and staff interviews the facility failed to complete a quarterly minimum data set (MDS) assessment with 92 days of the previous quarterly MDS assessment (Resident #2) and failed to complete discharge assessments within 14 days of the assessment reference date (Resident #1 and Resident #3). This affected 3 of 4 residents reviewed (Resident #1, Resident #2, and Resident #3). F656: Based on observations, record review, and	F 725	2) Audit to be completed by 2/11/22 by the Administrator, Director of Nursing and the IDT team to assess the facility current resident care acuity requirements to include incontinence care needs, wound management needs, and resident MDS assessment completion and transmission requirement and develop a plan to ensure the facility is providing sufficient staffing. The Regional Director of Operation to review the staffing plan by 2/11/22 with the Administrator to ensure implemented measures are in place to maintain adequate staffing levels. 3) The IDT team and the Director of Nursing were to be educated 2/11/22 by the Administrator on the facility staffing plan. Newly hired Director of Nursing and IDT team staff will be educated on hire. 4) The Administrator and the IDT team will review the facility staff plan to ensure measures remain in place for adequate staffing for 4 weeks and monthly for 3 months. The Administrator will report findings of the monitoring to the Interdisciplinary Team (IDT) during QAPI meetings monthly for three (3) months and will make changes to the plan as necessary to maintain compliance with providing adequate staffing level.	

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staff interviews, the facility failed to develop a comprehensive care plan for a resident with a known history of wandering for 1 of 2 residents reviewed for accidents (Resident #5).

An interview was conducted with NA #1 on 1/10 /2022 at 3:26 PM. NA #1 stated that on her unit they usually had 4 NAs through the week and only 2 NAs on the weekend. She stated that sometimes on the weekend the unit would have 1 NA to care for 37 residents. She stated, "we do the best we can." NA #1 indicated because of the lack of staff; her residents did not get incontinent care for an extended period. NA #1 stated they have a lot of complaints about patient care but there was just not enough of us to do everything that needed to be done.

An interview was conducted with NA #2 on 1/11/2022 at 9:30 AM. NA # 2 stated she had worked at the facility a little over 3 months and staffing is very bad. She stated that most of the time she works the 300 halls, which is the heaviest hall for total care patients. She stated on the weekends sometimes the hall only had one maybe two NAs and she was only able to provide incontinence care to her residents 1 time during her shift. NA #2 stated that she refused to work any extra weekends due to the fact she would be the only NA and it would be too much. She further stated that the administration staff offers no help or support.

An interview was conducted with NA #3 on 1/11/2022 at 9:42 AM. NA #3 stated that she is staffed through agency and had been at the facility about 4 months. She stated the facility had no permanent NAs on staff. She stated sometimes her unit had 4 NAs, but at times the

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unit had two or three NAs. NA #3 added, if we have four nurse aides on the entire unit that is good day. She added that on the weekends her unit had only one NA. NA #3 stated that the residents would get better care if we had more staff on the units, she stated that on days when the unit had 2 NAs the residents would go for long periods of time before getting incontinence care.

An interview was conducted with Nurse #1 on 1/11/2022 at 12:41 PM. Nurse #1 stated that she is agency staffed. She stated staffing is terrible. Honestly it should not happen, but we have one NA on the hall. Nurse #1 stated that it was unacceptable for residents to be soiled for long periods of time. She stated that showers were not consistently being completed because there was not enough staff.

An interview was conducted with Nurse #2 on 1/11/2022 at 1:34 PM. Nurse #2 stated that is normally the wound nurse, but she will work the nurse's cart when the facility had call outs. She stated that when she worked weekends, she had 37 residents to administer medications and perform wound treatments on her hall. Nurse #2 stated that the NAs had twenty plus residents and were unable to perform incontinence wounds every two- hours. She further stated that the facility had a lot of call outs from both Nurses and NAs.

An interview was conducted with the Director of Nursing (DON) on 1/11/2022 at 10:47 AM. The DON stated that she expected the facility to maintain a level of staff to meet the needs of the residents. She added that the facility utilized six different staffing agencies, they had job fairs, and

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F 725	Continued From page 37 had numerous advertisements for job openings. She added that she had a lot more agency staff in the facility than permanent staff. The DON stated that they usually did not work with one NA on the hall because she would put a nurse on the hall to perform patient care before she would let one NA work the hall alone. She further added that on the weekends the manager on call would come in and work if they had any call outs. An interview was conducted with the Administrator on 1/11/2022 at 2:45 PM. The Administrator stated she had not been at the facility long enough to assess the staffing issue within the building. She stated she would expect that there was enough staff to meet the safety and welfare needs of the residents.	F 725		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for	F 761		2/14/22

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F 761	Continued From page 38 storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility failed to secure an unattended medication cart for 1 of 5 (100 hall) observed medication carts. The findings included: An observation of Nurse #1 preparing medications on the 100 hall was made on 01/11/22 at 9:31 AM. Nurse #1 finished preparing the medication and took the medication cup that contained the medication and walked approximately 10 feet from the medication cart into a resident room to administer the medication without locking or securing the medication cart. The medication cart could not be visualized from the inside the resident room. There were staff and resident moving about on the unit during the time the medication cart was unlocked and unattended. A subsequent observation was made of the 100-hall medication cart on 01/11/22 at 2:26 PM. The medication cart was sitting on the 100 hall and was unlocked and unattended. There were several resident rooms that had their doors shut on the hallway. There was a male resident propelling himself up and down the hallway and staff were observed to be walking up and down the hallway.	F 761	1) 100 Hall nurse medication cart was secured on 1/10/22 by Director of Nurses. Education was provided to the identified nurse on 1/10/22 by Director of Nurses on ensuring medication cart is secured when unattended. 2) Medication Cart audit for 100, 200, 300 and 600 halls were audited by the Director of Nursing on 1/10/22 to ensure carts are being secured while unattended 3) Facility and agency Licensed nurses and Certified Medication aides will be educated by the Director of nurses/ designee by 2/13/22 on ensuring medication carts are locked when unattended. Newly hired licensed nurses and certified medication aides will to be educated in orientation upon hire. Facility and agency licensed nurses and Certified medication aides will not be allowed to work until education is completed. 4) Nurse managers to monitor 100, 200, 300 and 600 hall medication carts randomly 4 times a week for 4 weeks and monthly for 3 months to ensure medication carts are not unlocked when unattended. Nurse managers will report findings of the monitoring to the Interdisciplinary Team (IDT) during QAPI	

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F 761	Continued From page 39 An interview and observation were conducted with the Director of Nursing (DON) on 01/11/22 at 2:29 PM. The DON confirmed that the medication cart was unlocked and proceeded to push the lock in and secure the medication cart. An interview and observation were conducted with Nurse #1 on 01/22/22 at 2:30 PM. Nurse #1 was observed to exit a resident room on the 100 hall and approach the medication cart. Nurse #1 stated that she did not realize she had left her medication cart unlocked and explained she was still very new to the facility and was still learning the rules. Nurse #1 stated that she knew anytime she walked away from her medication cart that it should be locked. She added she was nervous because someone was observing her. A follow up interview was conducted with the DON on 01/11/22 at 3:37 PM. The DON stated she expected the medication carts to be locked or secured anytime the staff were not in sight of the medication cart.	F 761	meetings monthly for three (3) months and will make changes to the plan as necessary to maintain compliance with securing medication cards when unattended.	
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observation, record reviews and interviews the facility's Quality Assessment and Assurance (QAA) committee failed to maintain	F 867	1) Identified residents #10, #11, and #13 were COVID tested on 1/13/22 with no negative findings by nurse manager.	2/14/22

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F 867	Continued From page 40 implemented procedures and monitor the interventions that the committee put into place on 05/21/21. This was for one deficiency in the area of Infection Control that was originally cited on the 04/15/21 recertification survey. The deficiency was cited again on the current complaint investigation survey with an exit date of 01/14/22. The continued failure of the facility during the two federal surveys showed a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Program. The finding included: This citation is cross referred to: F-880: Based on observations, record review, local health department representative and staff interview, and the Center for Disease Control (CDC) COVID-19 Data Tracker for Iredell County transmission rate the facility failed to follow the CDC guidance regarding appropriate Personal Protective Equipment (PPE) for counties of high county transmission rates when 2 of 4 nurses (Nurse #1 and the Assistant Director of Nursing) administered medications to 3 of 3 residents (Resident #10, Resident #11, and Resident #13) without donning eye protection and 1 of 3 Nurse Aides (NA) #2 failed to wear eye protection while providing patient care (Resident #12). These failures occurred during a COVID-19 pandemic. During the recertification survey completed on 04/15/21 the facility was cited for failing to develop and implement a policy to follow guidelines established by the Center for Disease Control and Prevention (CDC) which indicated personal protective equipment (PPE) to include a gown, gloves, face mask, and eyewear were to	F 867	Identified Nurse#1, Nurse Aid #1, and Assistant Director of Nurses were educated on PPE and donning eyewear by Director of Nurses on 1/11/22. 2) Facility rounding assessment completed on 1/10/22 by the Director of Nursing and identified staff observed not wearing required Personal Protective Equipment (PPE) to include eyewear were reeducated on wearing the required PPE to include eye wear by the Director of Nurses. 3) Staff to include agency staff will be educated on the required PPE to include eyewear by 2/13/22 by the Director of Nursing (DON)/ designee. Newly hired staff will be educated on hire during orientation. Facility staff and agency staff will not be allowed to work until education is completed. 4) Director of Nurses and the Administrator to monitor 10 staff members randomly to ensure proper PPE to include eyewear is being worn in patient care areas weekly for 4 weeks and monthly for 3 months. will report findings of the monitoring to the Interdisciplinary Team (IDT) during QAPI meetings monthly for three (3) months and will make changes to the plan as necessary to maintain compliance with wearing appropriate Personal Protective Equipment.	

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F 867	Continued From page 41 be worn when in resident care areas for new admission who under quarantine resident with an unknown COVID-19 status reside for 3 of 3 staff observed on the new admission quarantine unit and prevent a contracted phlebotomist from wearing gloves in the hallway when she was observed at the central nurses station for 1 of 1 contracted staff member. An interview was conducted with the Administrator on 01/14/22 at 1:30 PM. The Administrator explained she had only been employed by the facility since mid-November 2021 and was not sure what the steps were that the facility developed to maintain compliance in the Infection Control program. She continued to explain that the administrative team were on the halls daily and monitored the staff for wearing their goggles and reminded them to apply their goggles. The Administrator stated she expected the staff to follow the infection control policy and wear their goggles when they were in the resident care areas.	F 867		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 880		2/14/22

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F 880	Continued From page 42 a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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F 880	Continued From page 43 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, local health department representative and staff interview the facility failed to follow the CDC guidance regarding appropriate Personal Protective Equipment (PPE) for counties of high county transmission rates when 2 of 4 nurses (Nurse #1 and the Assistant Director of Nursing) administered medications to 3 of 3 residents (Resident #10, Resident #11, and Resident #13) without donning eye protection and 1 of 3 Nurse Aides (NA) #2 failed to wear eye protection while providing patient care (Resident #12). The facility further failed to follow infection control guidelines when 1 of 1 wound care personnel (Wound Nurse) failed to remove gloves and perform hand hygiene during 2 of 3 wound observations (Resident #2 and Resident #3). These failures occurred during a COVID-19 pandemic. The findings included: CDC guidance titled "Interim Infection Prevention and Control Recommendations for Healthcare Personnel during the Coronavirus Disease 2019	F 880	Root Cause Analysis: On 2/10/22, the Administrator held an AdHoc Quality Assurance Process Improvement meeting with the IDT team and Medical Director to determine root cause of deficient infection control practices utilizing the Five Whys Tool. The facility determined that the primary root cause of the facility failure to follow CDC guidance regarding 1) appropriate Personal Protective Equipment (PPE) for counties of high county transmission rates due to Infection Preventionist unable to consistently focus on infection control when pulled to floor and taking on duties of other nurse managers to include Interim DON. and 2) the facilities failure to follow infection control guidelines for hand hygiene and glove use during wound care was due to facility Infection Preventionist unable to consistently focus on infection control when pulled to floor and taking on duties of other nurse managers to include Interim DON.	

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F 880	Continued From page 44 (COVID-19) Pandemic" updated on 09/10/21 indicated the following information under the section "Implement Universal Use of Personal Protective Equipment for Healthcare Personnel (HCP): If SARS-CoV-2 infection is not suspected in a patient presenting for care (based on symptom and exposure history), the HCP working in facilities located in counties with substantial or high transmission should also use PPE as described below: Eye protection (i.e., goggles or a face shield that covers the front and sides of the face) should be worn during all patient care encounters. Review of a facility policy titled, "Handwashing/Hand Hygiene" revised on August 2015 read in part, use an alcohol based hand rub containing at least 62% alcohol or alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: before and after direct contact with residents, before handling clean or soiled dressings, gauze pads etc., before moving from a contaminated body site to a clean body site during resident care, after contact with resident intact skin, after handling used dressings, after contact with object in the immediate vicinity of the resident and after removing gloves. On 01/10/22 and 01/11/22 the Centers for Disease Control and Prevention (CDC) COVID-19 Data Tracker was reviewed. The CDC Data Tracker revealed that the county where the facility was located had a high level of community transmission for COVID-19. 1a. An observation of Nurse #1 preparing Resident #10's medication was made on 01/10/22 at 9:31 AM. Nurse #1 was observed	F 880	1) Identified residents #10, #11, #12 and #13 were COVID tested on 1/13/22 with no negative findings by nurse manager. Identified Resident #2 and Resident #3 wounds were assessed by the Wound physician on 1/12/22 with no adverse findings or signs of infection. Identified Nurse#1, Nurse Aide #2, and Assistant Director of Nurses were reeducated on Transmission Based Precautions and PPE, including donning eyewear when providing patient care by Director of Nurses on 1/11/22. Wound Nurse was educated on 1/11/22 by Director of Nurses on performing hand hygiene when removing gloves and wearing proper PPE during wound care. 2) Monitoring of licensed nurses on 1/11/22 by Director of Nurses to ensure they are wearing appropriate PPE to include eyewear during medication administration was completed. Identified licensed nurses were educated on appropriate PPE to include goggles. Monitoring of certified nursing assistants and licensed nurses on 1/11/22 by Director of Nurses to ensure they are wearing appropriate PPE to include eyewear while providing patient care was completed. Identified certified nursing assistants and licensed nurses were educated on appropriate PPE to include	

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F 880	Continued From page 45 standing at her medication cart with a N95 mask in place and had goggles on top of her head. Once Nurse #1 had prepared Resident #10's medication she proceeded to Resident #10's room and entered the room to administer his medication. Nurse #1 did not pull down her goggles from the top of her head before entering or at any time she was in Resident #10's room. A subsequent observation of Nurse #1 was made on 01/10/22 at 2:30 PM. Nurse #1 was observed in Resident #13's room administering intravenous medications. Nurse #1 was observed to have on a N95 mask, and her goggles remained on top of her head during the medication administration. Nurse #1 was interviewed on 01/10/22 at 2:30 PM. Nurse #1 confirmed that she had her goggles on top of her head during both medication administrations with Resident #10 and Resident #13 and stated she just forgot to pull them down on her face before entering their rooms. Nurse #1 stated she was still new to the facility and was still learning all the rules. 1b. The Assistant Director of Nursing (ADON) was observed preparing medications for Resident #11 on 01/10/22 at 9:47 AM. Once the ADON had prepared the medication she proceeded into Resident #11's room wearing a N95 mask but no eye protection. The ADON was interviewed on 01/10/22 at 1:25 PM. The ADON also confirmed she was the Infection Preventionist at the facility. The ADON explained that if the resident room had no type of precautions then the staff should be wearing mask, gloves, and eye protection for source control since the facility remained in a county of	F 880	goggles. Current facility residents with wounds were reviewed by the Wound physician on 1/12/22 with no negative findings noted. Monitoring of licensed nurses on 1/12/22 by Nurse managers to ensure hand hygiene after removing gloves during wound care was completed with no negative findings. 3) The facility and agency licensed nurses will be educated by the DON/designee by 2/13/22 related to following the CDC guidance on PPE use and transmission based precautions by performing hand hygiene when removing gloves during wound care and donning/doffing appropriate PPE including eyewear to prevent infection. Newly hired licensed nurses will be educated on hand hygiene during orientation. Licensed nurses to include agency licensed nurses will not be allowed to work until education is completed. 4) Director of Nurses/ designee will monitor1) licensed nurses (5) when providing wound care to ensure licensed nurses are completing hand hygiene as required and 2) licensed nurses (5) and nurse aides (5) for proper use of PPE including eyewear during high county transmission rates. Monitoring will be completed weekly for 4 weeks and monthly for 3 months. The DON will report findings of the monitoring to the	

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F 880	Continued From page 46 high transmission. The ADON confirmed that at times she forgot to wear her eye protection and stated that earlier she had missed placed her eye protection and went a period of time without them until she found them. She again stated that the staff were expected to wear eye protection in resident care areas. 1c. Nurse Aide (NA) #2 was observed on 01/10/22 at 9:49 AM at Resident #12's bedside assisting the resident with his bed linen. NA #2 was observed to have a N95 mask in place but no eye protection. NA #2 was interviewed on 01/10/22 at 2:37 PM. NA #2 stated she had forgotten her goggles out in her car and she just remembered them and went outside and got them and put them on. An interview was conducted with the local Health Department Nurse on 01/10/22 at 11:25 AM who confirmed that the county in which the facility was located remained a county of high transmission for COVID-19 and the staff should be wearing eye protection in all resident care areas per the CDC guidelines. The Director of Nursing (DON) was interviewed on 01/10/22 at 3:37 PM. The DON stated the county in which the facility was located remained a county of high transmission of COVID-19 and she expected the staff to wear eye protection in all resident care areas and indicated that they had all been trained to do so. 2. An observation and interview were conducted with the Wound Nurse (WN) on 01/10/22 at 2:02 PM. The WN was observed to prepare for Resident #2's dressing change, gathered her	F 880	Interdisciplinary Team (IDT) during QAPI meetings monthly for three (3) months and will make changes to the plan as necessary to maintain compliance with hand hygiene. Effective 1/28/22 the facility is recruiting to obtain and hire a designated infection preventionist/staff development coordinator who will be designated to monitor on going infection prevention of the facility. to ensure monitoring of infection control prevention is maintained. The ADON who is a Certified Infection Control Preventionist whom will serve as the infection preventionist in the interim. Attestation of Infection Control has been attached and is signed by Infection Control Preventionist and members of Quality Assurance and Performance Improvement (QAPI) committee to validate accuracy of the educations and POC timeline information. Date of Compliance 2/14/22.	

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F 880	Continued From page 47	F 880		

supplies and entered Resident #2 's room. Once inside Resident #2's room the WN was observed to use alcohol-based hand sanitizer and don gloves. Once her gloves were donned, she proceeded to remove the soiled dressing to Resident #2's right lower leg. The dressing was visibility soiled with clear drainage once the wound was exposed the WN stated that Resident #2 had pseudomonas (type of bacteria) in the wound. The wound appeared very moist and white in color and was observed to have a large amount of teal/green macerated skin covering the area. The WN proceed to clean the wound with betadine and then saline and attempted to scrub the green macerated skin from the wound. Her gloves were covered with betadine and tiny pieces of the green macerated skin from Resident #2's wound on her right leg. Once the WN had cleaned the wound she proceeded to apply a clean gauze to the wound and then realized she had forgot the gauze wrap she would need to wrap the wound. The WN removed her gloves reached in her pocket and grabbed the keys to the treatment cart, unlocked the treatment cart open the drawer and obtained the gauze wrap she needed. She closed the cart locked it and replaced her keys in her pocket. The WN grabbed a pair of gloves from the top of the treatment cart donned them and re-entered Resident #2's room again and wrapped Resident #2's right lower leg. When the wound was complete the WN removed her gloves and proceeded to the bathroom to wash her hands.

The WN was again interviewed on 01/10/22 at 2:19 PM. The WN confirmed that she did not remove her gloves and sanitize her hands between removing the dirty dressing and applying the clean dressing and that she did not sanitize or

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wash her hands when she removed her gloves to obtained something off the treatment cart that she forgot. The WN stated she thought about using hand sanitizer but then stated I was going to apply clean gloves, so it seemed "crazy" to do that. She added that she was nervous and not used to being observed during wound care.

The Director of Nursing (DON) was interviewed on 01/10/22 at 3:37 PM. The DON stated that she expected the WN to use good infection control practices during her wound care each time she performed wound care. She stated that she expected the WN to remove her gloves and sanitize or wash her hands after removing the dirty/soiled dressing and before applying clean gloves. The DON further added if the WN forgot a supply on the treatment cart then she expected her to remove her gloves sanitize or wash her hands after obtaining the supplies and before donning clean gloves.

3. Review of a facility policy titled, "Handwashing/Hand Hygiene" revised on August 2015 read in part, use an alcohol based hand rub containing at least 62% alcohol or alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: before and after direct contact with residents, before handling clean or soiled dressings, gauze pads etc., before moving from a contaminated body site to a clean body site during resident care, after contact with resident intact skin, after handling used dressings, after contact with object in the immediate vicinity of the resident and after removing gloves.

An observation and interview were conducted with the Wound Nurse (WN) on 01/10/22 at 2:27

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PM. The WN was observed to prepare for Resident #3's dressing change, gathered her supplies and entered Resident #3's room. Once inside Resident #3's room the WN was observed to use alcohol-based hand sanitizer and don gloves. Once her gloves were donned, she proceeded to remove the soiled dressing to Resident #3's left hand. The wound was covered with black eschar. The WN proceed to clean the wound with saline and gauze. Once the WN had cleaned the wound she proceeded to apply a clean gauze moistened with betadine. When the WN attempted to wrap the wound with kerlix gauze she dropped the kerlix gauze on the floor, she then reached into her pocket retrieved her scissors and cut the kerlix guaze. After WN finished wrapping Resident #3's hand she removed her gloves and used alcohol-based hand sanitizer.

The WN was interviewed on 01/10/22 at 2:45 PM. The WN confirmed that she did not remove her gloves and sanitize her hands between removing the dirty dressing and applying the clean dressing. She also stated that she failed to clean her scissors prior to using them. She added that she was nervous and not used to being observed during wound care.

The Director of Nursing (DON) was interviewed on 01/10/22 at 3:37 PM. The DON stated that she expected the WN to use good infection control practices during her wound care each time she performed wound care. She stated that she expected the WN to remove her gloves and sanitize or wash her hands after removing the dirty/soiled dressing and before applying clean gloves.

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F 886	Continued From page 50	F 886		
F 886 SS=F	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the	F 886		2/14/22

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F 886	Continued From page 51 results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to perform COVID-19 Testing per manufacturer's instructions when 1 of 1 Nurse (Nurse #2) was observed completing a COVID-19 test for 1 of 50 residents (Resident #3). The facility was in COVID-19 outbreak status and this practice had the potential to affect all 50 residents tested by Nurse #2. Findings included: A review of the facility's COIVD-19 testing Guidelines revised 09/10/2021 indicated during	F 886	1. Identified Resident #3 COVID test was completed on 1/11/22 by Director of Nurses with no negative findings. Nurse #2 was reeducated on the manufactures instructions/competency by Director of Nurses on 1/11/22 2. Manufactures instructions for BinaxNOW were reviewed by the Director of Nurses and Administrator on 1/11/22 Residents from halls 100, 200, 300, and 600 were retested on 1/13/22 by Nurse	

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F 886	Continued From page 52 outbreak (any single new infection in staff or residents) all staff and residents would be tested when newly identified COVID-19 positive staff or residents were identified. Staff and residents who tested negative would be tested every 3 to 7 days until testing did not identify any new cases for at least 14 days. Review of the facility's COVID-19 testing Guidelines revised 9/10/2021 further revealed the facility can obtain a rapid Point of Care (POC) COVID - 19 tests in accordance with the manufacturer's instructions. A review of the manufacturer's instructions for Abbott BinaxNOW Covid-19 quick reference guide dated 12/2020 revealed that a nasal swab should be inserted into the nasal wall and rotated 5 times for a total of 15 seconds then remove slowly and repeat the process in the other nostril. The reference guide further stated that the test card should lay on a flat surface and wait 15 minutes before reading the test results, if read prior to the 15 minutes the test could give a false reading. An observation was made on 1/11/2022 at 12:20 PM, Nurse #2 performed a rapid COVID - 19 test on Resident #3 while sitting in the hallway at the nurse station. Nurse #2 inserted the nasal swab into the resident nostril for approximately 3 to 5 seconds then removed the swab and inserted into the second nostril for 3 to 5 seconds. Nurse #2 then sealed the test, reopened the COVID test and applied more control solutions and resealed the test. Nurse #2 then only waited 30 seconds and read the COVID - 19 test as negative results. Another observation was made on 1/11/2022 at	F 886	Manager. 3. Education and competency will be provided by 2/13/22 by the DON/designee to the facility and agency licensed nursing staff on COVID BinaxNOW testing manufactures instructions. Newly hired Licensed nurses will receive education upon hire during orientation. Agency and facility nurses will not be allowed to work until education is completed. 4. Nurse managers will monitor licensed nurses to ensure staff and residents are performing testing by the manufacture guidelines weekly for 4 weeks and monthly for 3 months. Nurse managers will report findings of the monitoring to the Interdisciplinary Team (IDT) during QAPI meetings monthly for three (3) months and will make changes to the plan as necessary to maintain compliance with reporting of alleged violations.	

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12:40 PM. Nurse #2 repeated another COVID-19 test on Resident #3 after nurse was prompted by the surveyor due to Nurse #2 not preforming the first COVID-19 test correctly. Nurse #2 inserted the swab into Resident #3 nostril for approximately 3 to 5 seconds then removed the swab and inserted into the second nostril for 3 to 5 seconds. Nurse #2 then read the COVID - 19 test in approximately 2 minutes with a negative test reading.

An interview was conducted with Nurse #2 on 1/11/2022 at 1:34 PM. She stated that she was trained to insert the swab into the nostrils and twirl for 5 seconds then remove. She stated that she did not wait the full 15 minutes to read the first test on Resident #3, because she knew the COVID test was contaminated when she opened the test to reapply more drops. Nurse #2 further stated that she had performed COVID-19 tests on all 50 residents located on the 100 and 300 halls when, and that she performed all test by only leaving the swab in each nostril for 5 seconds on 1/11/2022.

The facility In-Service for COVID 19 testing dated 9/13/2021 revealed that Nurse #2 was instructed on the proper way to perform the rapid BinaxNOW COVID test. On 9/13/2021 the facility also provided instruction to Nurse #2 on the appropriate way to obtain a nasal swab sample for COVID- 19 testing according to the Centers for Disease Control and Prevention (CDC) guidelines

An Interview with the Unit Manager was conducted on 1/11/2022 at 1:37 PM. The Unit Manager stated that she was trained to insert the swab into the nostril for 7 seconds, then remove

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and so the same process for the second nostril. She further stated that she waits 15 mins to read the results of the test.

An interview was conducted with the Assistant Director of Nursing (ADON) on 1/11/20 at 1:45 PM. The DON stated that she was trained to insert the swab in the nostril rotating the swab 5 times and leave the swab for 15 seconds, then repeat the process on the second nostril. She further stated that she waits 15 minutes to read the results of test, while leaving the test card on a flat surface.

The facility In-Service for COVID 19 testing dated 9/13/2021 revealed that Nurse #2 was instructed on the proper way to perform the rapid BinaxNOW COVID test. On 9/13/2021 the facility also provided instruction to Nurse #2 on the appropriate way to obtain a nasal swab sample for COVID- 19 testing according to the Centers for Disease Control and Prevention (CDC) guidelines.

An interview with the Administrator with the Director of Nursing present was conducted on 1/11/2022 at 3:00PM. She stated that the facility would have Nurse #2 re-educated on the proper way to obtain a nasal swab sample for COVID testing. She further stated that all residents on 100 and 300 halls would be retested that day (1/11/2022).

On 1/11/2022 at 7:30 PM the Administrator reported by telephone that all the residents on the 100 and 300 halls, including Resident #3, had been retested and were negative.