STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 09/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL SALISBURY	710 JULIAN ROAD SALISBURY, NC 28147

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E 000	Initial Comments An unannounced COVID - 19 Focused Infection Control survey was conducted from 7/27/20 through 9/1/20. The facility was found to not be in compliance with 42 CFR 483.80 infection control regulations and had not implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID - 19. Event ID #09CD11. A deficient practice was identified at: CFR 483.80 at tag F880 at a scope and severity (K) The deficient practice for F880 began on 7/27/20. The facility provided an allegation of compliance which was validated on 9/1/20 and the scope and severity was lowered to a level E as (a potential for than minimum level of harm) as of 8/26/20. The facility was found in compliance with 42 CFR 483.73 related to E - 0024 (b) (6), Subpart - B - Requirements for Long Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 7/27/20 to conduct an on-site revisit and a complaint investigation survey/Focused Infection Control Survey and left the facility on 7/30/20 with the investigation still open. Additional information was obtained through off-site record review and phone interviews from 7/31/20 through 9/1/20. Additional on-site observations and interviews were conducted on 8/3/20 and 8/25/20. A second Focused Infection Control survey was performed on 9/1/2020. 78 of the 137 complaint allegations were substantiated. The facility remained out of substantial compliance as a result of a tags cited	F 000		

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

Electronically Signed | 09/11/2020

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F 000	Continued From page 1 at F580, F584, F600, F677, F690, F692, F695, F725, F755, F760, F804, F806, F812, F880, and F925. Immediate Jeopardy (IJ) was identified and started on 7/27/20 and an allegation of compliance was removed as of 8/26/20 during a validation conducted on 9/1/20 when a member of the survey team returned to validate the immediate jeopardy allegation of removal. Please see event ID #09CD11 and event ID# UR4V12. The survey exit date was changed 9/1/20. Immediate Jeopardy was identified at: CFR 483.80 at tag F880 at a scope and severity (K) Tag F690 (level H) constituted Substandard Quality of Care. An onsite extended survey was conducted on 8/14/20.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial	F 580		9/22/20

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F 580	Continued From page 2 status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff and	F 580	This plan of correction is submitted as	

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F 580	Continued From page 3 resident interviews, the facility failed to notify a resident (Resident #23) of accurate COVID-19 test results for more than 24 hours after the incorrect notification was provided in 1 of 3 sampled residents and the facility failed to notify the physician of a Resident's (Resident #2) change in condition for 1 of 6 sampled residents. Resident #2 experienced an elevated temperature of 102.4 degrees Fahrenheit and received 1000 milligrams (mg) of an analgesic (pain reliever). The findings included: 1) Resident #23 was admitted in 2015 with diagnoses that included heart failure, chronic lung disease and COVID-19. The most recent comprehensive assessment, dated 07/15/2020, revealed Resident #23 had no cognitive impairment no communication deficits. On 07/27/2020 at 11:23 a.m. Resident #23 was interviewed and reported concerns with infection control signage that remained on the door of their room. The Resident stated that everyone in the facility was to be retested the previous week for COVID-19. Resident #23 stated they had approximately 100 cases of COVID 19 earlier in the spring. Resident #23 shared ongoing concerns and fears of catching COVID 19 again. Resident #23 stated, "I am a high-risk category and worried for my remaining friends in the facility." Resident #23 then stated that the isolation signage on the door of the room caused concern because it had been removed from other doors on the hall and the Resident had not been notified of the results of last Tuesday's (7/21/2020) test results.	F 580	required under Federal and State Regulation and statutes applicable to long term care providers. This plan of correction does not constitute an agreement by the facility and such liability is hereby specifically denied. The submission of the plan does not constitute an agreement by the facility that the surveyors' finding or conclusion are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are correctly applied. F-Tag 580 1.Corrective actions for those residents found to have been affected by the deficient practice. On 07/27/20 Resident #23 had isolation signage removed from the room door. On 7/28/20 the resident was notified of her test result by nurse #13. Resident #2 physician made aware of change in condition on 8/21/20 by the nurse on duty 2. Identify other residents who have the potential to be affected by the same deficient practice and what corrective actions were taken. All residents are at risk of deficient practice. A review of all vital signs and change of condition for the past 30 days has been completed by the Director of Nursing on 9/11/20. No further issues were noted with notification 3. Measure/ systemic practice put in place to ensure the deficient practice does not reoccur. On 8/20/20 the Director of Nursing and/ or	

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F 580	Continued From page 4 On 07/27/2020 at 12:09 p.m. Nurse #13 was interviewed and reported the infection control process for COVID-19. Nurse #13 reviewed Resident #23's electronic medical record and found no indication for the enhanced droplet isolation signage that remained on the resident's door to the room. Nurse #13 then reviewed Resident #18's, the roommate of Resident #23, electronic medical record and found no indication for the enhanced droplet isolation signage. Nurse #13 stated it was her understanding that the residents in the facility would be placed on enhanced droplet isolation for 14 days when they had been exposed to the community or post illness and both residents should be off isolation at this point. Nurse #13 then inquired with the Director of Nursing for further clarification. On 07/27/2020 at 12:20 p.m., the Director of Nursing (DON) was interviewed and stated that Resident #23 should not be on isolation. The DON stated that the results of the COVID-19 test from the previous week, 7/21/2020, arrived that morning, 07/27/2020, and all residents were negative. The DON stated the sign had not been removed but would be removed immediately. She sent Nurse #13 to the room and had the sign removed and told Nurse #13 to tell Resident #23 the test result was negative. On 07/27/2020 at 12:32 p.m., Nurse #13 was observed walking from the Director of Nursing office to Resident #23's room. Nurse #13 removed the enhanced droplet isolation signage from the door. Nurse #13 was observed standing just inside the doorway with Resident #23 sitting in a wheelchair beside the window and Resident #18 was sitting beside the doorway at the bedside table. Nurse #13 stated, "The test results for	F 580	designee was completed education for all licensed staff on change of condition and notification of physician and resident and/ or Responsible Party. 4. Monitoring of corrective action to ensure the deficient practice does not reoccur. The Director of Nursing, Staff Developing Coordinator and/or the Unit Manager will randomly audit 5 resident charts weekly to ensure appropriate notification for 4 weeks, and then 5 random charts monthly for 2 months The Administrator will present results of the audits to the Quality Assurance Performance Committee monthly for 3 months. The QAPI committee can modify this plan to ensure the facility remains in compliance	

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F 580	Continued From page 5	F 580		

COVID were all negative." She then said, "That's good, huh?" Resident #23 was observed smiling.

On 07/27/2020 at 12:36 p.m. Nurse #13 was interviewed and reported that she updated Resident #23 that the COVID 19 test results from the previous week were negative and that she removed the isolation signage. Nurse #13 stated she updated the Resident #23 based on orders to do so from the DON.

On 07/28/2020 at 4:28 p.m., Resident #23 was observed to be in a different room location.
An interview was conducted on 07/28/2020 at 4:35 p.m. with the Director of Nursing (DON). The DON stated Resident #23 was moved to the new location because of the COVID 19 test results and the COVID 19 infection control process. The DON clarified that five residents had inconclusive results and Resident #23 was one of the five. The DON stated the results were on the original spread sheet that the Administrator received from the laboratory office on 07/27/2020 and when the facility provided the results to all the residents they would have been informed of their results at that time. The DON did not provide a rationale for why she stated everyone was negative on the day before. The DON verified the inconclusive test results were available to the facility on 07/27/2020. The DON stated that all five inconclusive results were believed to be because the resident's had dementia and fought the staff during testing causing the staff to not be able to complete an accurate sample. When asked the process for notification of a resident whose cognition was intact, the DON stated a resident with intact cognition would be considered their own responsible party and would be the person the facility would update for new orders and

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results. The DON verified the cognition for Resident #23 in the electronic medical record and stated this resident did not have dementia as a cause for the inconclusive result.

An interview was conducted on 07/28/2020 at 5:02 p.m. with Resident #23. Resident #23 stated she had been informed by a nurse standing in her doorway on 07/27/2020 that the results were negative and on 07/28/2020 in the afternoon, staff appeared to tell her she was changing rooms because the test results were inconclusive, and she would need to be retested. Resident #23 stated the person that updated her about the inconclusive results did not appear aware she had been told the results were negative the day before.

2. Resident #2 was readmitted to the facility on 5/12/20 with medical diagnoses inclusive of chronic obstructive pulmonary disease (COPD), type 2 diabetes mellitus, and abnormalities of gait and mobility.

Resident #2's last quarterly Minimum Data Set (MDS) dated 6/5/20 revealed an assessment of intact cognition.

Resident #2's care plan included a focus area for at-risk for falls revised and an active diagnosis of COVID - 19 revised on 4/13/20.

Record review of Resident #2's physician orders included an order for Acetaminophen (Tylenol) tablet 1000mg by mouth every 12 hours as needed for pain.

Resident #2's medical record and medication administration record revealed she experienced an elevated temp of 102.4 degrees Fahrenheit on

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4/30/20 at 00:44 AM. Nurse #12 documented her temperature and the administration of 1000mg of Acetaminophen (an analgesic). Nurse #12 also documented Resident #2 was afebrile at 04:24 AM.

A review of Resident #2's hospital discharge summary note dated 5/12/20 indicated she was transferred to the hospital following a fall at the facility on 4/30/20. She was found to be in atrial fibrillation (irregular, often rapid heart rate commonly causing poor blood flow) with rapid ventricular rate (rapid or fluttering heartbeat). During her hospital course, infectious disease was consulted, and she appeared to have bacterial pneumonia in the setting of recent COVID -19 and was treated with antibiotics.

During a telephone interview with Nurse #12 on 8/3/2020 at 11:37 AM, he reported residents who had tested positive for coronavirus vital signs were obtained every shift. Nurse #12 was familiar with Resident #2; however, he could not recall most of the details from the morning of 4/30/20. When informed of Resident #2's elevated temperature and administration of Acetaminophen documented by him, he acknowledged that most likely he gave the medication ordered as-needed (Acetaminophen) for the fever. Nurse #12 reported that he had not contacted the physician to inform him of Resident #2's change of condition due to his understanding the facility was treating residents who had tested positive for coronavirus based on their symptoms and he felt giving her Acetaminophen was appropriate.

A telephone interview with Resident #2's physician on 8/5/2020 at 11:45 AM, he reported

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F 580	Continued From page 8 Resident #2 had an underlying medical diagnosis of COPD. The physician stated with Resident #2 having an elevated temperature and positive for coronavirus, he would have expected to be notified of her fever in order to order a chest x-ray, and antibiotics as needed to treat an infection. The physician also would have recommended contacting Resident #2's family to inquire whether they desired to have her treated at the facility or transferred to the hospital if results of chest x-ray indicated an infection. He also indicated Resident #2 had a history of falling prior to her admission to the facility and while she resided in the facility. The physician indicated he was contacted regarding the fall she experienced and gave orders to transfer her to the hospital. An interview was conducted with the interim Director of Nursing (DON) on 8/5/2020 at 12:06 PM. The interim DON reported nursing staff were expected to do a respiratory assessment along with vital signs each shift. The interim DON also stated residents who had tested positive for coronavirus that experienced a change in condition, nursing staff were expected to contact the physician and have the physician determine any new orders related to the resident's status. The interim DON indicated that Nurse #12 should have contacted the physician when Resident #2 experienced an elevated temperature. During an interview with the administrator on 8/5/2020 at 12:08 PM, she also stated nursing staff was expected to contact the physician when residents experienced a change in condition, especially in the case of Resident #2 who was diagnosed with COVID - 19.	F 580		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment	F 584		9/22/20

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F 584	Continued From page 9 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. §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	F 584		

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F 584	Continued From page 10 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain a clean and safe environment by failure to cover the fluorescent glass light bulbs in over the bed lights and not keep resident beds and over the bed lighting free of dust build up for eight of eight resident rooms reviewed for environment (204B, 205B, 211B, 317A, 319, 508B, 606A and 608B). Findings included: 1. Observations conducted on 7/29/20 from 8:45 AM to 11:26 AM of rooms 204B, 205B, 211B, 319, 508B, 606A, and 608B revealed exposed florescent light bulbs with no protective tubing or lens cover in the over the bed light. There were residents who resided in each observed room at the time of the observation. Observations conducted on 7/29/20 3:16 PM to 4:52 PM of rooms 205B, 211B, 317A, 319, 606A, and 608B revealed exposed florescent light bulbs with no protective tubing or lens cover in the over the bed light. There were residents who resided in each observed room at the time of the observation. Observations on 07/30/20 starting at 9:51 AM conducted in conjunction with an interview with the Maintenance Director (MD) of rooms 205B, 317A, 319, 508B, and 606A. Observations were made of the exposed florescent light bulbs with no protective tubing or lens cover in the over the bed light in each room. The MD stated no one	F 584	F-Tag 584 1. Protective coverings have been put in place for rooms 204B, 205B,211B, 317A, 319, 508B, 606A, and 608B on 8/19/20. The beds frames for rooms 205B, 211B, 319, 508B, 606A, and 608B have been cleaned on 7/31/20 2. A complete audit of the facility was performed by the Maintenance Director of overbed light bulb protectors and a total of 288 protectors ordered. The bed frames for all residents had been inspected for cleanliness by the Environmental Services Director on 8/12/20. No other concerns noted with the audit. 3. Environmental Services Director and staff were educated on 8/5/20 by the Environmental Services Regional Director on the proper technique to be used for cleaning bed frames. The Maintenance Director educated on the requirement of light protectors for fluorescent tubing by the Administrator on 9/9/20 in regards to reasoning of the safety measure requirements. 4. Audits are to be completed 5 x□s weekly by the Maintenance Director to ensure fluorescent tubing in the resident rooms have the protective covering weekly for 1 month and then 5 x□s monthly for 2 months. The Environmental Services Director will randomly audit 5 rooms weekly to ensure bed frames are cleaned properly for 1 month and then 5	

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had ever pointed out to him the fluorescent glass tubes in the over the bed lights did not have a protective covering and there was no one responsible for checking the over the bed lights for covers. The MD further stated florescent light bulbs should have had a lens cover or plastic tubing over the florescent glass tubes to protect a resident from glass fragments in case the glass tubing were to break.

A phone interview was conducted with the administrator on 8/4/20 at 2:41 PM. The Administrator stated it was her expectation for fluorescent light bulbs to have a protective covering on them to protect a resident in the event one of the glass florescent tubes were to break.

2. Observations conducted on 7/29/20 from 8:45 AM to 11:26 AM of rooms 204B, 205B, 211B, 319, 508B, 606A, and 608B revealed a dust build up on the bed frames and on wall mounted over the bed lights and bulbs. When the dust was wiped with a paper towel, a large amount of dust adhered to the paper towel, fell from the object, and left a trail where amongst the remaining dust showing where the dust buildup had been removed. There were residents who resided in each observed room at the time of the observation.

During an interview conducted on 7/29/20 at 11:12 AM with Housekeeper #1 she stated as part of her routine daily cleaning she wiped down the over the bed tables, swept and mopped the room, applied a sanitizer to high contact areas, and empty the garbage. She said she would usually do top dusting (dusting along the tops of lights, door frames, cabinets) but she was not top

x□s monthly for 2 months.

All audits will be presented to Quality Assurance Process Improvement committee monthly for 3 months, The QAPI committee can modify this plan to ensure facility remains in compliance.

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dusting currently. She further explained she was unable to because she did not have a dusting wand to do the top dusting. She said they were on order and it had been a while since she had a dusting wand to do top dusting.

An interview was conducted with the Housekeeping Director (HD) on 7/29/20 at 11:19 AM. She stated the daily cleaning of resident rooms included sanitizing high touch areas, doorknobs, over the bed tables, etc... empty the trash, sweep, and mop. She stated she was in the process of deep cleaning the A side of room 317, the bed and area around the bed next to the window. The HD explained as part of deep cleaning process the mattress and rails on the bed were wiped down. She said each side of each room is usually deep cleaned once per month. The HD further stated she had finished cleaning room 319, which was next door.

An observation conducted on 7/29/20 at 12:28 PM, of room 317 A side, after the room had been deep cleaned, revealed dust build up on the bed frames and on wall mounted over the bed lights and bulbs. When the dust was wiped with a paper towel, a large amount of dust adhered to the paper towel, fell from the object, and left a trail where amongst the remaining dust showing where the dust buildup had been removed.

Observations conducted on 7/29/20 3:16 PM to 4:52 PM of rooms 205B, 211B, 317A, 319, 606A, and 608B revealed a dust build up on the bed frames and on wall mounted over the bed lights and bulbs. When the dust was wiped with a paper towel, a large amount of dust adhered to the paper towel, fell from the object, and left a trail where amongst the remaining dust showing

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where the dust buildup had been removed. There were residents who resided in each observed room at the time of the observation.

Observations on 07/30/20 starting at 9:51 AM, conducted in conjunction with an interview with the HD, of rooms 205B, 317A, 319, 508B, and 606A. The HD stated she would use a dusting wand for high dusting and pulled a dusting wand from her cart. The HD explained they had a shipment of dusting wands had come in today (7/30/20). The HSK further stated Housekeeper #1 had come to her yesterday and told her she did not have a dusting wand to dust with and they had gone to the housekeeping cart of Housekeeper #1 and had discovered a high dusting wand in her cart. Observations revealed a dust build up on the bed frames and on wall mounted over the bed lights and bulbs. When the dust was wiped with a paper towel, a large amount of dust adhered to the paper towel, fell from the object, and left a trail where amongst the remaining dust showing where the dust buildup had been removed. There were residents who resided in each observed room at the time of the observation. The HD stated the observed bed frames needed to be dusted and it was her expectation for the dusting to have been completed so as there would not be a dust buildup. The HD also explained high dusting needed to be completed on the over the bed lights and she expected her housekeepers to utilize the dusting wands as part of the room cleaning process which included high dusting.

A phone interview was conducted with the administrator on 8/4/20 at 2:41 PM. Regarding the buildup of dust on the bed frame and on the over the bed lights, the Administrator said she

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F 584	Continued From page 14 would expect for those items to be dusted and cleaned as part of the routine cleaning and as part of the high dusting routine.	F 584		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility staff failed to prevent mistreatment of a resident by yelling comments and questions directly into a dependent resident's face while the resident was sitting on the floor, moving the resident after a fall without conducting an assessment and then failed to respond to the resident's verbal call for assistance over ten minutes for 1 of 1 resident (Resident #13). Findings: Resident #13 was admitted to the facility on 08/23/2019 with diagnoses of Parkinson's disease, Dementia, anxiety, depression, lack of coordination and repeated falls.	F 600	F-Tag 600 1.Corrective actions for those residents found to have been affected by the deficient practice. Resident #13 was assisted by nurse and nurse aid on 7/28/20 2. Identify other residents who have the potential to be affected by the same deficient practice and what corrective actions were taken. On 8/12/20 all alert and oriented resident were interviewed by Social Workers to ensure there were no allegations of abuse and/ or neglect 3. Measure/ systemic practice put in place	9/22/20

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F 600	Continued From page 15 A review of Resident #13's most recent comprehensive assessment, dated 07/09/2020, which revealed Resident #13 had adequate hearing, clear speech, able to communicate his needs and poor memory recall. Resident #13's functional status was coded as, requiring extensive assistance with bed mobility, transfers and locomotion on the unit. On 07/28/2020 at 5:28 p.m., Nurse #14 was observed walking down the 500 hall, asking for assistance in a room. Nurse #14 was observed to enter Resident #13's room. Resident #13 was observed sitting on the floor in his room, with his back against the bed. The Resident was wearing a shirt and a brief. Nurse #14 was observed standing in front of him, bent down and was yelling questions at Resident #13 without providing time for the resident to reply. The Nurse #14's face was observed only a couple inches from Resident #13's face as she very loudly asked the resident; "what are you doing?" and "didn't I tell you not to do that anymore?" Nurse #14 then yelled directly at the resident "you are killing me" and "God!", which was followed by the nurse making a loud grunting sound. At 5:29 p.m. nursing assistant (NA) #3 was observed to enter the resident's room as Nurse #14 was yelling at Resident #13. Nurse #14 and NA #3 were observed to put gloves on. Nurse #14 instructed NA #3 the two staff would assist Resident #13 to get back into bed. Nurse #14 and NA #3 put their arms under the resident's arms and lifted the resident onto the bed. Nurse #14 and NA #3 exited the resident's room at 5:33 p.m. without asking the Resident if he had pain, perform an assessment or take vital signs. Continuous observations of Resident #13 on 7/28/20 from 5:33 p.m. to 5:43 p.m. revealed the	F 600	to ensure the deficient practice does not reoccur. On 8/20/20 the Director of Nursing and/ or designee was completed for all staff on abuse and neglect policy and reporting guideline. 4. Monitoring of corrective action to ensure the deficient practice does not reoccur. The Director of Nursing, Administrator and /or designee will randomly interview 5 residents weekly to ensure there are no unreported allegation of abuse and/ or neglect 4 weeks, and then 5 random charts monthly for 2 months The Administrator will present results of the audits to the Quality Assurance Performance Committee monthly for 3 months. The QAPI committee can modify this plan to ensure the facility remains in compliance.	

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resident yelled help, help, help for nursing assistance with no one entering the room, during this 10-minute time period. Staff were observed walking past the resident's room without stopping to enter the room to check on Resident #13. Four staff, including Nurse #14, were observed sitting at the nursing station, within proximity of Resident #13's room, without responding.

The Administrator was interviewed on 07/28/2020 at 5:43 p.m. The Surveyor stated her observation to the Administrator. The Administrator stated that it was her expectation for staff to respond to the call of the Resident in a timely manner and speak in a calm voice. The Administrator observed Resident #13, then had a staff member respond to the resident's request for further assistance.

On 07/28/2020 at 6:26.p.m, Nursing Assistant (NA) #3 was interviewed. The NA stated that during the fall incident at 5:29 p.m., she observed that Nurse #14 was in Resident #13's "face and it was intimidating." She stated the resident was in the floor, unable to get up on his own and a staff member should not be "in his face". She did not feel comfortable with Nurse #14 using that body language or loud voice toward Resident #13. NA #3 stated she did not have to report the incident because an administrative staff member approached her. She was not able to recall the administrative staff members name.

On 07/28/2020 at 6:42 p.m. Resident #13 was not able to answer questions regarding the fall. Resident #13 was observed to be lying in bed, without yelling.

On 07/28/2020 at 6:56 p.m. The Regional Consultant was informed of the observations. The

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F 600	Continued From page 17 Regional consultant stated that Resident #13 was assessed to be without injury from the fall.	F 600		
F 677 SS=E	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 observations, record review and staff and Nurse Practitioner interviews, the facility failed to provide nail care for 3 of 3 dependent residents (Residents #4, #20 and #28) reviewed for Activities of Daily Living (ADL's). 1. Resident #28 was admitted to the facility on 3/7/19. The resident ' s cumulative diagnoses included: Generalized weakness, dementia, and cognitive communication deficit. Resident #28's most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 7/16/20. The resident was coded as having been cognitively intact. The resident was also coded as having required extensive assistance of one to two people for the following Activities of Daily Living (ADLs): Dressing, toilet use, personal hygiene, and was totally dependent for bathing. Resident #28's care plan, which was most recently revised on 7/30/20, revealed the resident had a Focus area of ADL self-care performance deficit related to dementia. There was an intervention listed to check the resident's nail	F 677	F-Tag 677 1. Resident#4, #20, and #28 have had fingernails trimmed and cleaned 8/5/20 2. All resident fingernails were visually observed by the Director of Nursing and / or designee on 9/8/20 to ensure proper nail care was being received. This observation also included visual evaluation of ADL care being provided. 3. On 8/20/20 the Director of Nursing educated all nursing staff on proper ADL care and fingernail care, including the documentation per policy and protocol 4. The Director of nursing and /or designee will randomly audit 5 residents visually 5x's weekly to ensure there is proper care provided for 4 weeks, and then 5 random residents monthly for 2 months The Administrator will present results of the audits to the Quality Assurance Performance Committee monthly for 3 months. The QAPI committee can modify this plan to ensure the facility remains in compliance.	9/22/20

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length, trim, and clean on bath day as necessary. The resident also had an intervention in which he needed assistance with washing his hands.

Resident #28's care guide for nursing assistants (NAs), as of 7/30/20, specified the resident was totally dependent on staff to offer a bath every day. Further review revealed the resident needed assistance with being shaved, hands, and face washed.

An observation of Resident #28's fingers conducted on 7/29/20 at 8:45 AM, while he was eating breakfast, revealed nine of nine fingernails, had dark debris under the free edge of each nail for all nine fingers. Further observation revealed the resident's free edge of each fingernail extended beyond the end of the resident's finger. The resident was using his hands to eat breakfast at the time of the observation.

An observation of Resident #28's fingers was conducted in conjunction with an interview with the resident on 7/30/20 at 9:47 AM. The observation revealed nine of nine fingernails, had dark debris under the free edge of each nail for all nine fingers. Further observation revealed the resident ' s free edge of each fingernail extended beyond the end of the resident ' s finger. The resident stated he would like to have his fingernails trimmed and cleaned.

An interview and observation were conducted with Nursing Assistant (NA) #1 on 7/30/20 at 2:13 PM. The NA stated Resident #28 was on her assignment on 7/29/20 and 7/30/20. An observation of Resident #28's fingers revealed nine of nine of the resident ' s fingernails had dark debris under the free edge of each nail and the

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free edge of the resident's fingernails extended beyond the end of the resident ' s fingers. NA #1 stated the resident's fingernails had debris under the nail free edge of the nails, the fingernails were long. The NA stated the resident used his hands to eat and she thought that may have been the reason his fingernails were dirty. The NA stated she had planned on trimming the resident ' s fingernails on 7/30/20. The NA stated her shift ended at 3:00 PM, but she thought she may have to stay a little longer. The NA stated she had cut another resident's fingernails on 7/29/20 but had not been able to cut Resident #28's fingernails yet. NA #1 stated she was unable to perform Resident #28's nail care because she had 14 residents on her assignment and did not have time. The NA said the resident ' s nails needed to be trimmed and cleaned.

An interview and observation were conducted with Nurse #2 on 7/30/20 at 2:21 PM. The nurse stated Resident #28 was on her assignment. The nurse observed the resident's fingernails and stated the resident ' s fingernails had dark debris under the free edge of the nail on nine of nine fingers. The nurse further stated the resident ' s nails needed to have been trimmed and cleaned.

An interview and observation were conducted on 7/30/20 at 2:31 PM with a nurse who stated she was a Director of Nursing from a facility owned by the company. Resident #28 was observed holding his hands in a bath basin of water. The nurse examined the resident's nails and stated the resident's fingernails had dark debris under the free edge of each nail and the free edge of the resident's fingernails extended beyond the end of the resident's fingertips on all nine fingers. The nurse stated it was the responsibility of the

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Nursing Assistants to provide nail care and Resident #28 required nail care. She further stated the resident's nails should be trimmed and cleaned on the resident's shower days and as needed. After viewing the resident's fingernails, she said the resident's nails needed to have been trimmed and cleaned.

During a phone interview conducted with the Administrator on 8/4/20 at 2:41 PM she stated she was made aware of Resident #28 having had dark debris under his fingernails and the need for them to be trimmed. She explained it was her expectation for residents to receive routine nail care on their shower days and nail care at other times as needed.
Based on observations, record review and staff and Nurse Practitioner interviews, the facility failed to provide nail care for 3 of 3 dependent residents (Residents #4, #20 and #50) reviewed for Activities of Daily Living (ADL's).

2. Resident #20 was admitted to the facility on 03/07/19. The resident's diagnoses included; disorders of muscle, autism, and seizures.

The resident's Quarterly Minimum Data Set completed 7/16/20 noted severely impaired cognition and required extensive assistance of 2 people for personal hygiene and was totally dependent for bathing.

Resident #20's care plan, which was most recently updated on 07/01/20, revealed a focus area of ADL self-care performance deficit related to impaired cognition due to autism and bipolar disorder. There was an intervention listed to provide 1-2 person assistance with ADL's.

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An observation of Resident #20 on 07/27/20 at 4:40 PM revealed NA #5 and NA #2 were repositioning Resident #20. The resident's nails on all fingers of both hands were noted to have thick lines of dark debris under the nails. NA #2 was heard to ask NA #5 to clean the resident's nails that evening, and NA #5 agreed.

An observation on 07/28/20 at 9:42 AM of Resident #20 revealed she was lying in bed awake and her nails were noted to have thick lines of dark debris under all the fingers.

Resident #20 was observed on 07/28/20 at 5:04 PM. The resident was awake lying in her bed, her nails remained with black debris under her nails as noted earlier.

An interview with NA #5 on 07/28/20 at 5:05 PM regarding the nail care for Resident #20 revealed he would cut nails, unless the resident was diabetic, and she was not. When asked about the request for completion of nail care yesterday he stated, "I didn't know that and I will clean them tonight."

An observation of Resident #20 at 12:55 PM on 08/04/20 revealed the nails on both hands had black debris under the nails on all fingers of both hands except the thumbs.

NA #6 was interviewed on 08/05/20 at 12:55 PM. NA #6 stated she was assigned to the 300 hall with Resident #20 and Resident #4. She stated the resident's nails should have been cleaned when showered or bathed. She noted the resident's nails were dirty and would be cleaned.

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An interview on 07/30/20 at 11:25 AM was conducted with the Nurse Practitioner (NP). The NP stated that nail care should be part of residents bathing and that dirty hands were a risk for infection. She said staff should clean the nails regularly and before meals if possible.

The Director of Nursing was interviewed on 07/28/20 at 5:24 PM regarding nail care. She stated that nail care should be done as needed, and checked when they cleaned the resident's hands, at least 1-2 times a day.

An interview was conducted with the administrator at 2:50 PM on 08/04/20 and she was informed that Resident #20 had dirty nails. She stated that staff should be cleaning the nails with baths and staff need to soak nails to get them clean if needed.

3. Resident #4 was admitted to the facility on 05/03/19. The resident's diagnoses included; hemiplegia, muscle weakness, dementia and acute/chronic respiratory failure.

The Minimum Data Set dated 07/20/20 for Resident #4 revealed no rejection of care. It was noted that the resident sometimes understood and had unclear speech. He was totally dependent on 1 person for toileting, personal hygiene and bathing.

The care plan for Resident #4 was updated on 05/30/20 and noted the resident had an ADL self-care performance deficit r/t Dementia and musculoskeletal impairment.

Observations of Resident #4 on 08/05/20 at 12:34 PM. revealed 3 of 5 nails of his left hand had

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black debris underneath the nails and black debris was underneath 4 of 5 fingernails of his right hand.

An interview was conducted with NA #7 on 08/05/20 at 12:48 PM regarding ADL care and nail care. She stated if they had enough staff they would do all the baths, showers and nail care that was needed. The NA said when staffing was lower it was harder to get showers and nail care completed.

NA #6 was interviewed on 08/05/20 at 12:55 PM. She was assigned to the 300 hall with Resident #4, and stated the resident's nails should have been cleaned when showered or bathed. She noted the resident's nails were dirty and would be cleaned.

An interview on 07/30/20 at 11:25 AM was conducted with the Nurse Practitioner (NP). The NP stated that nail care should be part of residents bathing and that dirty hands were a risk for infection. She said staff should clean the nails regularly and before meals if possible.

The Director of Nursing was interviewed on 07/28/20 at 5:24 PM regarding nail care. She stated that nail care should be done as needed, and checked when they cleaned the resident's hands, at least 1-2 times a day.

An interview was conducted with the administrator at 2:50 PM on 08/04/20 and she was informed that Resident #4 had dirty nails. She stated that staff should be cleaning the nails with baths and staff need to soak nails to get them clean if needed.

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F 690 SS=H	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by:	F 690		9/22/20

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F 690	Continued From page 25 Based on observations, record reviews, staff and resident interviews, Nurse Practitioner (NP) and Physician interviews the facility failed to provide overall care and services for a suprapubic urinary catheter for 1 of 1 resident reviewed with a urinary catheter. Resident #12 experienced skin infections around the insertion site of the urinary catheter and urinary tract infections (UTI) which resulted in the need for two emergency room visits for treatment and the need for antibiotics to be prescribed as part of the resident's treatment. The findings included: Resident #12 was admitted to the facility on 09/12/19. The diagnoses included diabetes, neurogenic bladder and Benign Prostatic Hypertrophy. The Quarterly Minimum Data Set completed 02/10/20 indicated the resident was cognitively intact. He was coded as being independent for toileting and indicated he had the catheter. The care plan written on 03/16/20 did not address urinary catheter care or Activities of Daily Living (ADL's). A physician order was written on 02/24/20, to return to Urology office for a 31 day suprapubic urinary catheter change and to change the insertion site dressing every other day. The urinary catheter change was completed in the urology office on 02/24/20. Review of the resident's February 2020 Medication Administration Record (MAR) indicated the order to change the suprapubic catheter site dressing every other day, written on	F 690	F-Tag 690 1. Resident #12 has had his orders reviewed, physician and family updates and Supra Pubic catheter changed. Appropriate Orders were put into placed on 8/14/20 by the Regional Clinical Services Consultant. 2. All residents with a catheter have had their orders reviewed for accuracy and appropriateness by the Director of Nursing on 9/11/20.A review of the documentation for changing and cleaning the catheter was completed by the Director of nursing No further issues noted. 3. All Licensed staff were educated by the Director of Nursing on the policy and procedures for supra pubic catheters on 8/13/20 including documentation of physician orders, changing the catheter, and cleaning the area around the catheter. Newly hired staff and contracted staff will be educated prior to working on the floor by the Staff Development Coordinator. 4. The Director of Nursing and/ or designee will randomly audit 5 residents weekly to ensure the catheter care is being provided and changes are being done per policy 4 weeks, and then 5 random charts monthly for 2 months The Administrator will present results of the audits to the Quality Assurance Performance Committee monthly for 3 months. The QAPI committee can modify this plan to ensure the facility remains in compliance.	

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02/25/20 was not documented as being completed on 2/25/20, 2/27/20 or 2/29/20.

Review of the MAR and the treatment administration record from 04/01/20 through 08/14/20 revealed there was no order for the suprapubic urinary catheter to be changed on a regular basis.

An interview with Urology Office Staff #1 on 08/13/20 at 3:50 PM was done who stated the resident's catheter was changed at the Urology office before COVID-19 on 02/24/20 and 03/27/20.

Additional orders were added on 03/23/20 for catheter care every shift, and on 03/27/20 to clean the suprapubic catheter site with 50% H2O2 (hydrogen peroxide) daily and empty the catheter bag every shift.

Review of the resident's March 2020 Medication Administration Record indicated the order to change the suprapubic catheter site dressing every other day, written on 02/25/20 was not documented as being completed on 3/2/20, 3/18/20, 3/20/20.

Review of the resident's March 2020 and April 2020 Medication Administration Record (MAR) revealed the cleaning of the suprapubic catheter site with 50% H2O2 ordered daily, was not documented as being performed on 03/27/20, 04/1/20, 04/16/20, 04/17/20, 04/25/20, 04/26/20, 04/29/20. Catheter care ordered every shift on 03/23/20 was not documented for 15 shifts in April, checking placement of the leg strap ordered 03/23/20 was not documented for 15 shifts in April, use of an anchoring device ordered

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03/23/20 and emptying the catheter bag ordered 03/23/20 was not documented for 15 shifts in April.

A nursing note from Nurse #20 on 04/19/20 at 8:02 PM noted the resident was sent to a local hospital per family request due to a clogged suprapubic catheter.

An interview was done on 08/14/20 at 3:18 PM with Nurse #20 who cared for the resident on 04/19/20. She said the resident had told her he was trying to urinate and could not, and he was in pain. She stated she tried to flush it and it would not flush. She stated the resident was on the phone with a family member and he was sent out to the Emergency Department per the family member's request. She had notified the physician prior to transfer and physician gave an order for transfer. She recalled the catheter had crusting around the site when the catheter care was done, and this was not relayed to the physician.

A physician order was written on 04/19/20 at 5:00 PM to send the resident to the local Emergency Room per family to see Urology.

Hospital records revealed Resident #12 was seen in the Emergency Department on 4/19/20 for suprapubic urinary catheter dysfunction, with the chief complaint that the urinary catheter was not draining. The resident was also treated for a skin infection or cellulitis around the suprapubic insertion site and oral antibiotics were ordered. A new suprapubic catheter was placed in the Emergency Department on 04/19/20.

A nursing progress note from 04/20/20 at 7:07AM

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noted the resident was seen in the Emergency Department (ED) and treated for cellulitis and an acute UTI, and the urinary catheter was changed. Antibiotics were ordered.

The physician order from 03/27/20 to clean the suprapubic urinary catheter site with 50% H2O2 daily, was updated on 04/28/20 to read, clean the resident's suprapubic catheter site with 50% H2O2 daily, every evening shift and as needed.

Review of the resident's May 2020 MAR prior to a May 6, 2020 ED visit, revealed the physician order to clean the suprapubic catheter site with 50% H2O2 was not documented as being performed on 05/01/20, 05/02/20, 05/03/20 and 05/05/20. The order to empty the catheter bag written on 03/27/20 was not documented as being completed for 28 shifts in May.

An interview was conducted with Nurse #16 on 07/30/20 at 1:38 PM. He cared for Resident #12 on 05/01/20 and did not document on the MAR that the catheter care, including emptying the catheter bag was performed. He stated if it was not checked off it wasn't done. He stated he worked intermittently at the facility and did not recall why he did not provide the resident's catheter care.

A record review from 05/05/20 was done of a nursing note from the Director of Nursing (DON #1) that indicated the suprapubic catheter was reviewed by the team for appropriateness, the resident preferred a leg bag and had been educated on how to empty the leg bag, the orders were appropriate and the care plan was done. There was no additional information of staff education or staff responsibilities in relation to the

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urinary catheter.

The care plan was not updated to reflect the resident's preferences or his education on the suprapubic catheter.

A record review of a nurse's note on 05/06/20 documented that Resident #12 informed Nurse #21 that he had not produced any urine from the urinary catheter for the 7AM-3PM shift. Nurse #21 irrigated the suprapubic urinary catheter. At 8:00 PM the resident informed them that no urine was draining into the bag and he was voiding urine every 20 minutes from his penis and had called his family member. The resident's family member spoke with the nurse and told her that she had notified the Urologist and the Medical Director. The family member informed Nurse #21 that the Urologist wanted him sent to the Emergency Department. The nurse confirmed this with the Medical Director and resident was transported.

Nurse #21 was interviewed on 08/17/20 at 1:50 PM that cared for the resident on 05/06/20 and recalled sending him out to the hospital. She stated the resident drained his own urine from the leg bag and when he had complications, he let the staff know. He had reported to her that there was no urinary output and she thought he was on antibiotics at the time. She stated he had a dressing change with a drain sponge and she recalled no signs of infection. She said when the resident had complications, he let the staff know and from what she recalled they had not changed his catheter even though the resident was unable to go out to the Urology office for a catheter change. She had cared for the resident on 05/02/20, 05/03/20, 05/11/20, 05/12/20, 05/13/20

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and 05/20/20 and had not documented the catheter care, cleaning the site, emptying the foley bag, checking the catheter strap or securement with an anchoring device. She stated if she had not documented it, she had not completed it.

An interview with Nurse #21 was conducted on 08/17/20 at 1:20 PM regarding the urine output from the suprapubic catheter. She had cared for Resident #12 on 05/05/20 and 05/06/20 and stated the resident emptied the urine from his bag, and she had not verified the resident had emptied the collection bag.

A progress note dated 5/6/2020 at 5:50 PM from the Medical Director noted the resident's family member had called him on his cell phone and told him that Resident #12 had not produced urine since 11 PM last night. The family member had also called the Urologist on call. The family member told the Medical Director the Urologist wanted him sent to the Emergency Room. The Medical Director documented that he notified the nursing staff to transport him to the Emergency Room.

A record review of the hospital discharge summary indicated Resident #12 was seen in the Emergency Department on 05/06/20 for acute cystitis with hematuria and suprapubic dysfunction. He was treated with an antibiotic for the urinary tract infection (UTI). The hospital records noted that the catheter was clogged and was replaced. The Emergency Department patient education discharge instructions from the 05/06/20 visit included to clean the stoma daily with soap and water.

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The Quarterly Minimum Data Set completed 05/6/20 indicated the resident was cognitively intact and able to make his needs known. The catheter was coded in the assessment. He required the assistance of 1 person with bathing and no assistance with eating, walking, toileting or personal hygiene.

A nurse's note dated 05/07/20 at 1:52 AM indicated the resident had been treated at the Emergency Department, the urinary catheter was changed and was draining blood tinged urine. She noted Resident #12 was treated for a UTI and an antibiotic was ordered.

The resident's medication administration record (MAR) for May 2020 and June 2020 noted that the evening catheter care with 50% H2O2 was not documented 05/11/20, 05/12/20, 05/13/20, 05/20/20 and 05/28/20, 06/01/20, 06/06/20, 06/11/20 or 06/15/20. In addition, the catheter care ordered every shift was not documented 26 times in May 2020 and 9 times in June 2020.

Nurse #15 was interviewed on 07/29/20 at 1:27 PM, as she had cared for the resident on 06/15/20 7:00 PM-7:00 AM. The nurse stated she did not recall the orders for catheter care being done when she was asked about 3 of the 4 treatments that had not been signed off. The orders were for catheter care, to check leg strap placement, empty the catheter bag and ensure the catheter tubing was secured with an anchoring device. She stated if she had seen it and completed the catheter care, she would have documented it on the MAR.

Resident #12's electronic care Plan dated 05/29/20 did not address the resident having a

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urinary catheter.

A review of the medical record indicated a note from Nurse #18 on 06/10/20 at 1:15 PM, that when she went to change his urinary catheter, and the resident said his family member told him to refuse for it to be changed. The nurse left a message for the family member.

An interview with Nurse #18 was done on 08/14/20 at 1:35 PM, she stated she had cared for the resident frequently. She said the resident went to the Urologist for urinary catheter changes until the facility had a large number of COVID cases, and they would not see him in the office. She responded that any nurse with training should be able to change it, but the family member initially did not want them to change it. The wife had told them in May that home health would change the catheter, and later the RP found out it was not permitted by the home health agency to perform treatments at a skilled nursing facility. The nurse stated she cleaned around the catheter and put a dressing on it daily and applied the antibiotic when ordered. She stated the site would get red as he would not empty the bag regularly. She noted that would remind him to empty the bag more frequently.

A nurse's note from the ADON on 06/10/20 at 1:50 PM documented communication with the family member that the Urology office would be setting up home health to come change the catheter and the family member would call back with the arrangements.

A nurse's note was reviewed from 06/29/20 at 6:55 PM that noted the urinary catheter was changed and was draining yellow urine. Nurse #2

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indicated that redness and drainage were noted at the suprapubic catheter site. The NP was contacted and assessed the area, and stated the area was infected and to call the Physician for possible orders. The facility Physician was notified and new orders were given for an antibiotic. (7 weeks and 5 days since the last catheter change).

A record review indicated a urine culture was done on 06/30/20 and the results indicated a UTI and Resident #12 was started on an antibiotic for the UTI.

An observation was done on 07/27/20 at 11:16 AM of Resident #12's catheter site. The dressing was intact, the tubing was anchored with Velcro straps to the upper thigh and was connected to a leg bag.

An interview with NA #2 was completed on 07/27/20 at 3:10 PM. She stated she cared for Resident #12 and emptied his foley catheter bag. She stated he was independent with his bathing and was able to do 90% of his care by himself.

An observation was done on 07/28/20 at 9:50 AM, the resident was lying in bed, the urinary catheter tubing was secured to the leg with a Velcro strap and the urine was draining into a leg bag.

On 07/28/20 at 5:10 PM, Nurse #5 was interviewed. She was assigned to care for Resident #12 on 07/27/20 and 07/28/20 for the 7:00 AM-7:00 PM shift. She stated yesterday she cleaned around the catheter site with normal saline. When asked what the catheter site looked like yesterday, she said she could not recall and

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had not completed the catheter care today. She stated he had a shower today and there was no dressing on the site now. The catheter care was ordered to be done for every 8 hour shift with 50% H2O2.

An interview was conducted with Resident #12 on 07/27/20 at 11:18 AM. He stated the staff cleaned his suprapubic urinary catheter site about once a week. The resident stated he had trouble lately with infections.

Resident #12 was interviewed on 07/28/20 at 9:51 AM. He stated his catheter was changed a few weeks ago and it was supposed to be changed once a month. He said the site was cleaned and the dressing around it was changed every couple weeks. He stated he emptied the catheter bag usually once a day.

Record review of the NP note from 07/29/20 at 3:30 PM noted excoriation to the suprapubic catheter site. Bactroban was ordered to be applied to the insertion site and she noted more frequent emptying of the bag was suggested to the resident. No additional orders were written.

On 07/30/20 at 11:25 AM an interview was conducted with the NP regarding Resident #12's catheter care. She stated she saw him on 07/29/20 and the catheter care cleaning around the site not being done put him very much at risk for infection, and staff must find time for it to be done. She stated the suprapubic urinary catheter should be changed every 30 days. The NP said she assessed it yesterday and he had redness around the catheter stoma. She had started a new order for topical antibiotics daily for an infection.

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An interview was completed on 08/14/20 at 2:29 PM with Nurse #19. She cared for the resident on 08/02/20 from 10:00 AM-9:00 PM and the physician orders for cleaning the urinary catheter site with 50% H2O2 , dressing change, urinary catheter care, securement with an anchoring device and catheter leg strap and emptying the catheter bag every shift were not signed off. She stated the resident cared for the catheter himself and she believed he had peroxide at the bedside to clean it. She stated "I may have failed to do the whole order" as she thought he did it himself. She stated, "I didn't look at the catheter or site." She was not aware of the process for changing his catheter, and stated she thought he went out of the facility for it.

An order was written on 08/14/20 by the facility's Medical Director for the catheter to be changed every 30 days. The urinary catheter was then scheduled to be changed on 08/17/20. (it had been 7 weeks for the catheter change).

An interview was conducted on 8/14/20 at 3:51 PM with Resident #12, he stated he emptied the urine leg bag once a day, and the dressing has been off for about a week. The resident said that he had not been instructed on the frequency to empty the bag. He stated the nurses very rarely came in and cleaned it. He said the catheter was last changed at the nursing home. There was no hydrogen peroxide at his bedside he said, and he stated he did not clean the catheter site. He stated there were 1-2 nurses lately that would do catheter care and one of the nurses was there that day. He stated they did not clean it when they put the ointment on it.

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The resident representative (RP) was interviewed on 08/14/20 at 2:46 PM. She stated her husband had told her the staff were not flushing the catheter and it clogged. She stated the former DON told her he had to go out for the urinary catheter to be changed. She stated at first with COVID-19, she had asked the facility not to change it but the Urology office required the resident to have two negative COVID tests for an appointment. The RP said the Medical Director told her the NP could change it. She stated the ADON changed it in June and it had not been changed since then. Later when she found out there was a NP on site 5 days a week and the catheter was some 20 days out from needing to be replaced. She stated the urinary catheter was late again to be changed, and they aren't flushing or cleaning the site. The RP stated the facility made him empty the bag and the bag had broken before from being too full. She said in May her husband told her he went 22 hours without urine draining into the bag.

An interview with the DON #1 occurred on 08/14/20 at 3:05 PM who stated the order to change the urinary catheter should have come from the physician and should have been on the Medication Administration Record (MAR) or the Treatment Record (TAR). She said the nurses at the facility would change the suprapubic urinary catheter with an order.

On 08/14/20 at 11:10 AM an interview was done with Nurse #5. She stated Resident #12's catheter would be changed on 08/17/20 with the new order written that day, and she had no idea when the last time it was changed. She stated she had completed catheter care once on her 12 hour shift and put ointment on but did not put a

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F 690	Continued From page 37	F 690		

dressing on it. She stated there was no order for a dressing. She said she had cleaned it with soap and water and applied the ointment. She stated the redness had increased around the site yesterday and she was going to talk with the NP today about it. Review of the MAR noted a dressing was to be applied with catheter care, written on 04/29/20.

An interview with the NP was done on 08/14/20 at 11:27 AM and she stated there should be a dressing around the insertion site. She had heard the site was worse and she had not seen him yet today.

An interview with the Urologist on 08/18/20 at 8:58 AM was conducted. He stated the catheter should be changed every 4-6 weeks. The Urologist stated that they had attempted to have home health change the catheter at the nursing home. The Urology office staff were told that home health would not be able to do treatments at a nursing facility. With COVID-19 the resident was not able to come to the office due to having the virus and the outbreak at the facility. He said it was important to complete the catheter care, empty the drainage bag each shift and ensure the catheter was anchored and the leg strap was utilized to prevent pulling on the site. The Urologist stated it was normal to have some bacteria in the urine with a suprapubic catheter and was important to monitor for signs of infection.

An interview was done at 2:28 PM on 07/30/20 with the Medical Director regarding the resident's urinary catheter stoma cleaning, dressing changes and catheter care, not being completed. He stated he followed the guidelines from the

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F 690	Continued From page 38 Urologist when he wrote the orders and he would expect perfection with this. He said the care needed to be followed as the orders stated, and this resident had frequent UTI's and cellulitis around the catheter. The physician noted that care should have included changing the catheter, anchoring the tubing, cleaning around the urinary catheter, emptying the drainage bag and ensuring the strap was secured on the leg. An interview was completed with the Assistant Director of Nursing on 07/30/20 at 2:03 PM related to the urinary catheter care orders for Resident #12 not being done or documented. She stated that documentation should be completed as this was the only way to prove it was done. The Director of Nursing #1 was interviewed on 07/28/20 at 5:24 PM. She stated a Registered Nurse or Licensed Practical Nurse could change the suprapubic urinary catheter and they usually are changed monthly. The DON #1 said the orders for the catheter change and catheter care should have been completed and documented. The Administrator was interviewed on 08/04/20 at 2:50 PM regarding Resident #12's the suprapubic urinary catheter not being changed regularly, and the catheter care not being completed per the physician orders and documented. She stated the catheter should have been changed and the suprapubic catheter care completed as ordered.	F 690		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes,	F 692		9/22/20

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F 692	Continued From page 39 both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and review of medical records, the facility failed to provide nutritional supplements (ice cream, fortified juice and a high calorie health shake) to prevent weight loss to 2 of 4 residents sampled for nutrition/hydration status (Residents #4 and #2). The findings included: 1. Resident #4 was admitted to the facility on 4/29/20. Diagnoses included vascular dementia, hypertension, hyperlipidemia, adult failure to thrive, and protein calorie malnutrition, among others. The April 2020 care plan for Resident #4 assessed him at risk for nutrition decline due to a	F 692	F-Tag 692 1. Resident 2 and #4 have had their supplements reviewed for accuracy by the Director of Nursing. 2. All residents have had their orders reviewed by the Director of Nursing on dietary supplements to ensure proper documentation in Point Click Care on 9/11/20. No further concerns noted. 3. Dietary Manager has received education on ensuring supplements are on meal trays per tray cards on 8/12/20. 4. The Dietary Manager and /or designee will randomly audit 5 residents with supplements on tray cards weekly to ensure the tray cards and meal trays are accurate for 4 weeks, and then 5 random tray and tray cards monthly for 2 months	

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F 692	Continued From page 40 history of significant weight loss with a goal to maintain adequate nutritional status. Interventions included providing and serving nutritional supplements of fortified juice with lunch, ice cream and a high calorie health shake with his breakfast, lunch and dinner meals. A quarterly Minimum Data Set dated 7/20/20 assessed Resident #4 with impaired cognition, unclear speech, sometimes able to understand/be understood, total dependence on staff for assistance with eating, and weight loss, but not on a physician prescribed weight loss plan. His medical record documented the following physician orders for nutritional support: - 5/7/20, fortified juice at lunch - 7/17/20, ice cream with each meal - 7/21/20, fortified shakes on every meal tray for nutritional support Review of July 2020 food intake records revealed Resident #4 primarily ate less than 50% of his meals as evidenced by 9 meals at 0-25% and 21 meals at 26 - 50%. Review of his weight data revealed a 2.2% (2.2 pounds) weight loss in 3 months and 3.7% (4 pounds) in 1 month, as evidenced by the following weight data: - 5/6/20, 107.4 pounds - 6/10/20, 109.1 pounds - 7/9/20, 105.2 pounds Review of the dietitian's progress notes, dated 5/6/20, 7/15/20 and 7/23/20 revealed a review for persistent significant weight loss with recommendations for ice cream at all meals, health shakes at all meals and fortified juice with	F 692	The Administrator will present results of the audits to the Quality Assurance Performance Committee monthly for 3 months. The QAPI committee can modify this plan to ensure the facility remains in compliance.	

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lunch.

Resident #4 was observed on 7/29/20 at 1:10 PM, fed by nurse aide #9 (NA #9). The diet tray card documented Resident #4 should have received fortified juice and a health shake with his lunch. The physician's order for ice cream at each meal was not documented on the diet tray card. Resident #4 did not receive the fortified juice, ice cream or health shake with his lunch meal. During the observation, NA #9 stated she had not been assigned to assist Resident #4 before and she was not aware that he should receive nutritional supplements with his lunch. She stated, "No one told me." NA #9 stated she had been trained to review the diet tray card to make sure residents received all items listed. NA #9 stated she also fed Resident #4 his breakfast meal that morning, but that he did not receive ice cream with his breakfast meal because it was not listed on the diet tray card.

Resident #4 was observed on 7/30/30 at 1:37 PM fed lunch by staff. His lunch meal diet card did not record ice cream was to be provided with his lunch meal. Resident #4 did not receive ice cream with his lunch meal.

An interview with the Dietary Manager (DM) occurred on 7/30/20 at 12:15 PM and revealed fortified juice, ice cream and fortified health shakes should be placed on meal trays by dietary staff. The DM further stated that she typically monitored meal trays for accuracy, but that she had not completed a meal tray audit since June 2020. She stated that the diet tray card should record all nutritional supplements ordered by the physician.

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An interview with the Administrator occurred on 7/30/20 at 1:30 PM and revealed she expected dietary concerns to be addressed by management with staff re-education, monitoring and audits.

The registered dietitian (RD) was interviewed via phone on 7/31/20 at 4:25 PM. The interview revealed she expected Resident #4 to receive ice cream and fortified health shakes with each meal, and fortified juice with his lunch for continued weight gain. The RD stated, that the additional calories from nutritional supplements would be helpful for Resident #4 because she stated, "I'm hoping his weight will continue to go up."

2. Resident #2 was admitted to the facility on 2/28/20 and re-admitted on 5/12/20. Diagnoses included type 2 diabetes mellitus, anemia and edema, among others.

An admission Minimum Data Set (MDS), dated 3/6/20 and a quarterly MDS dated 6/5/20 both assessed Resident #2 with intact cognition, adequate vision, clear speech, able to understand and be understood, and independent with eating after staff assistance with set up.

A care plan for Resident #2, revised April 2020, identified a nutrition risk for malnutrition due to a history of significant weight loss. The goal was that Resident #2 would not sustain significant weight changes. Interventions included to provide fortified juice on her lunch tray as ordered by the physician.

Review of her medical record revealed a physician's order date 5/28/20 for 6 ounces fortified juice at lunch.

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Review of her weight data revealed stable weights for the last 3 months as evidenced by the following:
- 5/18/20, 133.4 pounds
- 6/10/20, 134.6 pounds
- 7/24/20, 136.8 pounds

Resident #2 was observed eating lunch on 7/29/20 at 1:25 PM and at 1:50 PM and again on 7/30/20 at 1:43 PM. Her lunch meal diet card recorded she should receive fortified juice at lunch. Resident #2 did not receive fortified juice with her lunch meal on 7/29/20 or 7/30/20. Resident #2 stated that this occurred often but by the time she realized it, staff had already left the room before she could request it. She also stated that when she did request it, she did not always receive the fortified juice. The speech therapist (ST) was observed assisting Resident #2 on 7/30/20 at lunch.

An interview with the Dietary Manager (DM) occurred on 7/30/20 at 12:15 PM and revealed fortified juice should be placed on meal trays by dietary staff. The DM further stated that she typically monitored meal trays for accuracy, but that she had not completed a meal tray audit since June 2020.

An interview with the Administrator occurred on 7/30/20 at 1:30 PM and revealed she expected dietary concerns to be addressed by management with staff re-education, monitoring and audits.

An interview with the Registered Dietitian (RD) occurred via phone on 7/31/20 at 4:40 PM. The RD stated Resident #2 had a history of weight

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F 692	Continued From page 44 loss and that her current weight was below her baseline admission weight of 145 pounds. The RD stated that the fortified juice was a recommendation for nutritional support to help prevent continued weight loss and that Resident #2 should continue to receive it because of her nutrition risk factors. A telephone interview occurred on 7/31/20 at 5:00 PM with the ST. During the interview, the ST stated she assisted Resident #2 to cut up her meat during her lunch meal on 7/30/20. The ST stated that she remembered that Resident #2 received iced tea for lunch, but that she did not recall the Resident receiving any other beverages or supplements. The ST also stated that she usually reviewed the diet tray card to make sure the resident received all items listed on the diet card, but that she could not confirm that she did that when she assisted Resident #2 for lunch on 7/30/20.	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and record review, the facility failed to provide oxygen therapy per physician order for 1	F 695	F-Tag 695 1. Resident #2 has had her oxygen order verified by the Director of Nursing	9/22/20

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F 695	Continued From page 45 of 4 residents reviewed for respiratory care (Resident #2). Findings included: Resident #2 was readmitted to the facility on 5/12/2020. Her diagnoses were inclusive of chronic obstructive pulmonary disease (COPD) and coronavirus. Resident #2 had a plan of care in place dated 4/8/2020 related to Covid-19 diagnoses. Interventions were inclusive of administering oxygen per physician order. Resident #2 quarterly Minimum Data Set (MDS) dated 6/5/2020 revealed she was cognitively intact. She was coded as receiving oxygen therapy. Resident #2 was not coded as exhibiting behavioral symptoms. Review of the July 2020 physician order read: Oxygen Therapy at 2 liters per minute continuous. An observation was completed on 7/29/2020 at 10:53 AM of Resident #2. She was observed sitting edge of bed with her nasal cannula applied to her nares. Her in-room oxygen concentrator was observed to be set on 1 liter. She verbalized she wore her oxygen daily except for when walking in the hallway. She had no signs or symptoms of respiratory distress. Additional observations of Resident #2 were completed on 7/29/2020 at 1:25 PM and 3:39 PM. The in-room oxygen concentrator remained set at 1 liter. No signs or symptoms of respiratory distress observed.	F 695	2. All residents on oxygen orders have been verified by the Director of Nursing and/ or designee on 8/26/20 3. Nursing staff have been educated on oxygen settings and verification. 4. The Director of Nursing and /or designee will randomly audit 5 residents weekly to ensure oxygen is set correctly 4 weeks, and then 5 random charts monthly for 2 months The Administrator will present results of the audits to the Quality Assurance Performance Committee monthly for 3 months. The QAPI committee can modify this plan to ensure the facility remains in compliance.	

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An interview was completed on 7/29/2020 at 3:42 PM with Nurse #6. She verbalized she was not aware of Resident #2 manipulating her oxygen settings. Nurse #6 stated she had not received in report that Resident #2 manipulated her oxygen settings. An observation was completed of Nurse #6 obtaining an oxygen saturation of Resident #2 which read 95%. The nurse verified Resident #2's current physician order which notated oxygen at 2 liters. Nurse #6 communicated she had not observed Resident #2's in-room oxygen setting throughout the day. Nurse #6 immediately corrected Resident #2's in-room oxygen concentrator setting and set the in-room oxygen concentrator at the physician ordered rate of 2 liters.

An interview was completed with the Nurse Practitioner (NP) on 7/29/2020 at 3:59 PM. The NP explained nursing should be monitoring those residents on continuous oxygen and those residents on as needed oxygen. She continued to explain residents should be on the physician ordered setting for oxygen therapy. In-room oxygen concentrators and portable oxygen tanks should also be maintained and monitored to ensure they were operational and functioning.

An interview was completed with the Director of Nursing (DON) on 7/29/2020 at 4:18 PM. She explained Resident #2 had a history of manipulating oxygen settings on her in-room oxygen concentrator but this behavior was not exhibited daily. The DON communicated the nurses were responsible for monitoring oxygen and oxygen settings.

An interview was completed with Social Worker

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F 695	Continued From page 47 (SW) #1 and #2 on 7/29/2020 at 4:54 PM. Both SW's verbalized they were not aware of Resident #2 exhibiting manipulative behaviors with her in-room oxygen concentrator. Both SW's communicated no behavioral care plan had been developed for Resident #2 regarding manipulative behaviors.	F 695		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §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	F 725		9/22/20

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F 725	Continued From page 48 by: Based on record review, observations, resident interviews, and Nurse Practitioner and Physician interviews the facility failed to provide sufficient staffing to ensure 1 of 7 residents reviewed for medication administration, Resident # 18, received medications as ordered by the physician and the facility failed to provide nail care for 2 of 3 dependent residents, Resident #4 and Resident #28, reviewed for Activities of Daily Living (ADLs). Findings included: 1.a. Resident #18 admitted to the facility on 4/8/2019 with diagnosis of Parkinson's Disease. A Quarterly Minimum Data Set (MDS) assessment dated 5/8/2020 revealed Resident #18 was cognitively intact. A Physician's Order dated 7/13/2020 from the Neurologist for Carbidopa/Levodopa 25/100 milligrams stated it was medically necessary and important to follow dosing times daily for Resident #18's Parkinson's Disease management. On 7/22/2020 the Physician ordered Carbidopa-Levodopa 25/100 milligrams give 1 tablet at 6:00 am and 2 tablets at 9:00 am, 12:00 pm, 5:00 pm and 9:00 pm for Parkinson's Disease. During an observation and interview with Resident #18 on 7/28/2020 at 4:16 pm she stated if she did not receive her Parkinson's Medication (Carbidopa/Levodopa) on time each day she had difficulty moving. Resident #18 stated there were many times she did not get her medication within one hour of the time it was ordered, and she had	F 725	F-Tag 725 1. Added resources, additional personal from sister facilities and agencies have been obtained to observe and ensure resident needs are continually met beginning on 7/27/20 2. All resident have the potential to be affected by the nursing staffing level within the facility. The Administrator/ Director of Nursing and/or designee will review the nursing schedule daily to ensure sufficient staff are in the facility. 3. The Nursing Scheduler has been educated on the minimal needs of the facility to provide nursing care appropriately to the residents on 8/26/20 by the Director of Nursing 4. Nursing staff schedule will be reviewed by the Administrator, Director of Nursing, and/ or designee 5 times weekly for the next 12 weeks to ensure appropriate staffing levels for resident care. The Director of Nursing and/or designee will randomly audit 5 resident weekly through observations to ensure appropriate ADL care is given, then 5 times monthly for 2 months. The Director of Nursing and/or designee will randomly audit 5 medications passes weekly to ensure timely medication pass, then 5x's monthly for 2 months. The Administrator will present results of the audits to the Quality Assurance Performance Committee monthly for 3 months. The QAPI committee can modify this plan to ensure the facility remains in compliance.	

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difficulty moving and sitting up in her chair when her medication was given later than ordered.

Resident #18's Neurologist was interviewed on 7/29/2020 at 10:30 am and he stated if her Parkinson's Medication (Carbidopa/Levodopa) was given more than one hour after it was due it could be harmful, and she would not be able to move as well.

An interview was conducted with Director of Nursing #1 on 7/29/2020 at 12:15 pm and she stated Resident #18 was on a unit that had recently been divided into two assignments because the nurse was not able to complete their medication administration pass within a reasonable time or within one hour of the administration time.

During an interview on 7/30/2020 at 10:23 am with Nurse #6 she stated she worked at the facility on 5/24/2020 and she was not able to give Resident #18 her medications within an hour of the time they were ordered. Nurse #6 stated there were so many residents on the 200 Hall unit it was impossible for the nurse on that unit to given medications on time.

An interview conducted with Nurse #10 on 7/30/2020 at 10:38 am revealed she had worked the evening shift on 5/24/2020 and had given Resident #18's medications late because there were almost 40 residents on the assignment. Nurse #10 stated with the staffing for 200 Hall unit it was impossible to give the medications within one hour of the scheduled time.

On 7/30/2020 at 11:08 Nurse #11 was interviewed and stated she had cared for Resident #18 on

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several evening shifts in July and she was not able to give her Parkson's Disease medication within one hour of the medication administration time. Nurse #11 stated the 200 Hall unit consisted of almost 40 residents with only one nurse it was impossible to complete the medication administration pass within one hour of the ordered medication times. Nurse #11 stated before the staffing of 200 Hall was changed in July 2020, she was not able to give medications on time on the evening shift.

During an interview with Nurse #1 on 7/30/2020 at 11:31 am she stated she worked on 7/8/2020 and was late giving Resident #18 her medications. Nurse #1 stated the staffing of one nurse for the many residents on the 200 Hall made it impossible to complete the Medication Administration Pass within one hour of the medication ordered time.

An interview with Nurse Practitioner #1 on 7/30/2020 at 1:01 pm revealed she felt administering Resident #18's Carbidopa/Levodopa later than one hour after the scheduled times could be harmful. Nurse Practitioner #1 stated giving the Carbidopa/Levodopa too late could cause the resident's tremors to be worse and could have led to a fall.

During an interview with the Physician on 8/3/2020 at 9:32 am he stated giving Resident #18's Carbidopa/Levodopa to far apart could result her "freezing up" or not being able to move and giving it to close together could cause hallucinations and confusion. The Physician stated Resident #18's Parkinson's Disease was stable, and she had not complained of any

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worsening symptoms to him.

2.a. Resident #4 was admitted to the facility on 5/3/2019 with diagnoses of hemiplegia and dementia.
A Minimum Data Set (MDS) quarterly assessment dated 7/20/2020 revealed Resident #4 was severely cognitively impaired and required extensive assistance with person hygiene.

Resident #4's Care Plan that was updated on 5/30/2020 revealed he required assistance with Activities of Daily Living (ADLs) due to dementia and decreased mobility.

An observation of Resident #4 on 8/5/2020 at 12:34 pm revealed he had black debris found under his fingernails on 3 of 5 fingers of his left hand and 4 of 5 fingers of his right hand.

During an interview with Nurse Aide #7 on 8/5/2020 at 12:48 pm she stated if they had enough staff, they would do all the baths, showers and nail care that was needed. She stated it was difficult for her to provide nail care when staffing was low.

Nurse Aide #6 was interviewed on 8/5/2020 at 12:55 pm and stated she was assigned to the 300 Hall and took care of Resident #4. She stated Resident #4's nails should have been cleaned when he was showered or bathed.

On 8/18/2020 at 2:20 pm an interview with Director of Nursing #2 was conducted and she stated staffing was a challenge. Director of Nursing #2 stated she was doing the best she could right now with staffing and when she had the enough staff, she made sure the nail care

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was done.

A follow up interview was conducted on 8/18/2020 at 3:10 pm with the Administrator. She stated staffing had been challenging and they had to use agency staffing. She stated the agency staffing did not know the residents as well and it took longer for them to provide care and sometimes they did not show up as scheduled. The Administrator stated she felt that nail care had suffered from the staffing and the care was not what she wanted for the residents.

2.b. Resident #28 admitted to the facility on 3/7/2019 with diagnoses of weakness, dementia, and cognitive communication deficits.

The most recent Minimum Data Set (MDS) assessment for Resident #28 was a quarterly assessment dated 7/16/2020. The assessment stated Resident #28 was cognitively intact and required extensive assistance of two people for personal hygiene and was totally dependent for bathing.

Resident #28's care plan dated 7/30/2020 revealed he required assistance with personal care due to dementia. One of the interventions listed was to check Resident #28's nail length, trim, and clean nails on bath day as necessary. There was also an intervention for Resident #28 requiring assistance with washing his hands.

A Care Guide for the Nursing Assistants for Resident #28 dated 7/30/20 stated the resident was totally dependent on staff for bathing and personal care every day. The Care Guide also stated Resident #28 needed assistance with washing his hand.

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An observation of Resident #28 on 7/30/2020 at 9:47 am revealed the free edge of each fingernail extended beyond the end of his fingers. Resident #28 stated he would like to have his fingernails trimmed and cleaned.

During an interview and observation with Nursing Assistant #1 on 7/30/2020 at 2:13 pm she stated Resident #28 was on her assignment on 7/29/2020 and 7/30/2020. An observation of Resident #28 revealed nine of nine of the resident's fingernails extended beyond the end of the resident's fingers. Nurse Aide #1 stated Resident #28's fingernails had debris under the nail free edge and the fingernails were long. Nurse Aide #1 stated she was not able to perform Resident #28's nail care because she had 14 residents on her assignment and did not have time.

During an interview on 7/30/2020 at 2:31 pm with a Nurse who stated she was a Director of Nursing from another facility owned by the company, she stated the Nurse Aides are responsible for providing nail care. She stated nail care should be provided on the resident's shower days and as needed. The Nurse was observed holding Resident #28's hands in a basin of water. She examined the nails and stated they needed to have been trimmed and cleaned.

On 8/4/2020 at 2:41 pm an interview was conducted with the Administrator and she stated she was made aware of Resident #28's nails having dark debris under the fingernails and the need for them to be trimmed. The Administrator stated the residents should receive routine nail care on their shower days and as needed.

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F 725	Continued From page 54 On 8/18/2020 at 2:20 pm an interview with Director of Nursing #2 was conducted and she stated staffing was a challenge. Director of Nursing #2 stated she was doing the best she could right now with staffing and when she had the enough staff, she made sure the nail care was done. A follow up interview was conducted on 8/18/2020 at 3:10 pm with the Administrator. She stated staffing had been challenging and they had to use agency staffing. She stated the agency staffing did not know the residents as well and it took longer for them to provide care and the agency staff did not show up as scheduled at times. The Administrator stated she felt that nail care had suffered from the staffing and the care was not what she wanted for the residents.	F 725		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility	F 755		9/22/20

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F 755	Continued From page 55 must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interviews, Pharmacist, Nurse Practitioner, and Physician interviews the facility failed to acquire and administer potassium chloride for a resident, that received diuretic medication; and failed to acquire and administer diuretic and heart medication for a resident with atrial fibrillation and congestive heart failure for 2 of 7 residents reviewed for medication administration (Resident #1 and Resident #14). Findings included: 1. Resident #1 admitted to the facility 11/13/2019 with diagnoses of heart failure, pulmonary disease, and hypokalemia. The most recent Quarterly Minimum Data (MDS) assessment dated 7/1/2020 revealed Resident #1 was cognitively intact, and she received diuretics for 7 of 7 days during the assessment.	F 755	F-Tag 755 1. Resident #1 and resident #14 have received their medications from pharmacy and has been given on 7/28/20 2. Director of Nursing to reviewed medication refill requests from the past 30 days for all residents to ensure all medication have been received from the pharmacy 3. Director of Nursing, Regional Clinical Service Director and or designee will educate Licensed staff and the procedure of follow up with medication refill requests prior to medication being unavailable. This education will be provided for new staff and contracted staff prior to working the floor 4. The Director of Nursing and /or designee will randomly audit 5 residents weekly to ensure medication refills are requested in a timely manner and received within 24 hours from the	

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F 755	Continued From page 56 Resident #1's Physician's Order dated 2/9/2020 revealed an order for Potassium Chloride 20 milliequivalents by mouth one time a day for hypokalemia. A physician's order for Resident #1 was written on 2/16/2020 for Torsemide 20 milligrams two times a day and the order was chanced to Torsemide 40 milligrams two times a day for increased edema on 7/11/2020. Torsemide is a diuretic with a side effect of low blood potassium levels. Resident #1's July 2020 Medication Administration Record revealed her physician's ordered Potassium Chloride 20 milliequivalents was not given on 7/8/2020, 7/15/2020, 7/17/2020, 7/19/2020, 7/20/2020, 7/21/2020 or 7/22/2020. An interview was conducted with Resident #1 on 7/28/2020 at 9:50 am. She stated she had missed several doses of her Potassium Chloride in July 2020 and was concerned because she took a diuretic. A Nurse's Progress Note dated 7/8/2020 at 9:49 am written by Nurse #1 stated Resident #1's Potassium Chloride Supplement was not available and was ordered from the pharmacy and the nurse was waiting for arrival of the medication. An interview with Nurse #1 on 7/28/2020 at 11:10 am revealed she had worked at the facility on 7/8/2020 and had cared for Resident #1. Nurse #1 stated she remembered Resident #1's Potassium was missing, and she had ordered it from the pharmacy, and she did miss administering the dose on 7/8/2020 because it was not available.	F 755	pharmacy for 4 weeks, and then 5 random charts monthly for 2 months. The Director of Nursing/ designee will review the 24 hour report in Point Click Care for eMAR documentation of medication not given during morning stand up meeting and follow up with the staff and pharmacy to ensure prompt delivery. This review will be provided to the Quality Assurance and Process Improvement committee for recommendations and further review. The Administrator will present results of the audits to the Quality Assurance Performance Committee monthly for 3 months. The QAPI committee can modify this plan to ensure the facility remains in compliance	

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Review of a Nurse's Progress Note dated 7/15/2020 at 9:51 am written by Nurse #2 revealed the dose of Potassium Chloride was not available.

On 7/17/2020 at 9:41 am the Nurse's Progress Note written by Nurse #2 stated the dose of Potassium Chloride was missed.

A Nurse's Progress Note dated 7/20/2020 at 9:52 pm written by Nurse #2 revealed the dose of Potassium Chloride was not available.

During an interview with Nurse #2 on 7/28/2020 at 11:32 am she stated she remembered Resident #1 and had reordered her Potassium Chloride several times and remembered she could not give it because it was not available on 7/15/2020, 7/17/2020, 7/19/2020 and 7/20/2020. Nurse #2 stated she called the pharmacy to order the Potassium Chloride for the doses that were unavailable.

A Nurse's Progress Note dated 7/22/2020 at 9:47 am by Nurse #4 revealed she had reordered Resident #1's Potassium Chloride from the pharmacy because the medication was unavailable.

During an interview with Nurse #4 on 7/27/2020 at 11:15 am she stated she worked for an agency but had cared for Resident #1 for one week. Nurse #4 stated she had issues with getting Resident #1's Potassium Chloride from the pharmacy and it had taken her 24 hours to get the medication and she had missed giving the dose on 7/22/2020.

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A Physician's Progress note dated 7/21/2020 at 3:10 pm stated Resident #1 told the Physician she had not received ordered medication. The medication was Potassium Chloride and the note further stated Nurse #3 told the Physician the medication was reordered that morning. The Physician's Progress Note also stated Resident #1 was a long-term resident due to heart failure and kidney disease.

During an interview with Nurse Practitioner #1 on 7/30/2020 at 11:45 am she stated she was not made aware of Resident #1's Potassium Chloride not being available 7/8/2020, 7/15/2020, 7/17/2020, 7/19/2020, 7/20/2020 and 7/21/2020. Nurse Practitioner #1 stated Resident #1 was prescribed a diuretic and not receiving the Potassium Chloride could have potentially caused her harm. She stated the diuretic could have lowered Resident #1's Potassium levels without the Potassium Chloride supplement which could have led to an abnormal heart rhythm.

An interview with the Physician on 8/3/2020 at 9:38 am revealed he was not notified Resident #1 had missed doses of Potassium Chloride on 7/8/2020, 7/15/2020, 7/17/2020, 7/19/2020, 7/20/2020 and 7/21/2020. The Physician stated Resident #1 was on a diuretic and decreased Potassium levels could lead to an abnormal heart rhythm. He stated Resident #1 did not have an episode of hypokalemia and she did not complain of symptoms of hypokalemia.

On 8/4/2020 at 4:36 pm the Pharmacist stated the facility had ordered Resident #1's Potassium Chloride on 5/26/2020 and 7/22/2020 and had received 30 doses on those dates. The Pharmacist stated the facility did not request

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enough Potassium Chloride to ensure Resident #1 had enough doses to administer through 7/2020. The Pharmacist stated the pharmacy had not received the requests sent by the nurses. The Pharmacist stated she did not know why the pharmacy did not receive the requests for Resident #1's Potassium Chloride. The Pharmacist also stated the Pharmacy did not automatically refill the resident's medications and the nurse should have sent a faxed request for a refill of the medication.

An interview with the former Director of Nursing on 8/14/2020 at 3:05 pm revealed she sometimes had an issue with the pharmacy getting medications to the facility. She stated if the Nurses did not send the request before 11:30 am the medications did not arrive until the next day. The former Director of Nursing did not realize they should order the medications when there was a 5-day supply left to ensure there were no gaps. She stated she did an education with the nurses but did not recall the dates but knew it was within the past month or two.

The current Director of Nursing was interviewed on 8/14/2020 at 5:00 pm and stated she realized there was a problem with ordering of medication and she had provided education for the staff regarding how to order medication through the computer system or faxing the pharmacy when they have at least 5 days of medication left for the resident. The current Director of Nursing stated the medication cards had a blue background when they have 5 days of medication left to remind the nurses to order the medication. The current Director of Nursing stated she completed the education on 8/13/2020.

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2. Resident #14 admitted to the facility on 9/19/2015 and had diagnoses of atrial fibrillation and congestive heart failure.

On 2/18/2020 a Physician's Order for Resident #14 was written for Hydrochlorothiazide, a diuretic medication, 50 milligrams give one tablet three times a day for edema.

A Physician's Order for Resident #14 dated 2/19/2020 stated Propafenone Capsule give 325 milligrams two times a day for atrial fibrillation.

A quarterly Minimum Data Set (MDS) assessment dated 7/1/2020 revealed Resident #14 was cognitively intact, and she received diuretic medication on 7 days of the 7-day observation period.

A review of Resident #14's Medication Administration Record for 4/2020 revealed she had doses documented as not given of Propafenone 325 milligrams on 4/10/2020 at 9:00 am and 9:00 pm and Hydrochlorothiazide 50 milligrams on 4/8/2020 at 9:00 am; 2:00 pm and 9:00 pm and on 4/9/2020 at 9:00 am and 2:00 pm.

Resident #14's Medication Administration Record for 8/2020 was reviewed and doses of Propafenone 325 milligrams were not documented as given on 8/4/2020 and 8/5/2020 for the 8:00 am and 9:00 pm doses.

An interview with Nurse # 9 was conducted 7/31/2020 at 2:31 pm and she stated she did not have Resident #14's Propafenone 325 mg capsules to administer when she worked on 4/10/2020. She stated she had looked for the

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medication and documented it was not given when she could not find it and had called the pharmacy to order the medication.

During an interview with Nurse #17 on 8/3/2020 at 11:05 am she stated she did not have Resident #14's Hydrochlorothiazide 50 milligrams available on 4/8/2020 for the 9:00 am and 2:00 pm doses. She stated she had ordered the medication from the pharmacy.

Nurse Practitioner #2 was interviewed on 8/3/2020 at 3:54 pm and she stated Resident #14 could be harmed by not being administered her Hydrochlorothiazide 50 mg and Propafenone since her congestive heart failure and atrial fibrillation were not stable.

During an interview with the Administrator on 8/3/2020 at 4:20 pm she stated the nurses should have ordered Resident #14's medications per the facility's policy.

An interview was conducted with Resident #14 on 8/14/2020 and she stated she could not remember when she had not received her heart medication, but she knew she had not received it for two consecutive days recently. Resident #14 stated she was concerned that she had not received her medication as the physician had ordered.

On 8/14/2020 at 2:05 pm Nurse #4 stated she was not able to give Resident #14's Propafenone on 8/5/2020 for the 9:00 am dose because it was not available, but she stated she did order it from the pharmacy.

An interview with the Pharmacist on 8/14/2020 at

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 62 2:21 pm revealed Resident #14 received a 14-day supply (28 pills) of Propafenone 325 milligrams on 7/19/2020. She stated the supply would not have been enough medication to last until 8/5/2020. The Pharmacist stated missing two days of the Propafenone could have affected Resident #14's atrial fibrillation and could have been harmful. An interview with the former Director of Nursing on 8/14/2020 at 3:05 pm revealed she sometimes had an issue with the pharmacy getting medications to the facility. She stated if the Nurses did not send the request before 11:30 am the medications did not arrive until the next day. The former Director of Nursing did not realize they should order the medications when there was a 5-day supply left to ensure there were no gaps. She stated she did an education with the nurses but did not recall the dates but knew it was within the past month or two. The current Director of Nursing was interviewed on 8/14/2020 at 5:00 pm and stated she realized there was a problem with ordering of medication and she had provided education for the staff regarding how to order medication through the computer system or faxing the pharmacy when they have at least 5 days of medication left for the resident. The current Director of Nursing stated the medication cards had a blue background when they have 5 days of medication left to remind the nurses to order the medication. The current Director of Nursing stated she completed the education on 8/13/2020.	F 755		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2)	F 760		9/22/20

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F 760	Continued From page 63 The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, staff interviews, Pharmacist, Nurse Practitioner and Physician interviews the facility failed to administer medications to 3 of 7 residents, Resident #1, Resident #14, and #18, reviewed for medications not given according to physician's orders. Resident #1 did not receive doses of Potassium Chloride, which was given as a supplement to prevent decreased potassium levels because the resident received a diuretic; Resident #14 did not receive doses of a diuretic and a heart medication; and Resident #18 did not receive Parkinson's Medication (Carbidopa/Levodopa) within the administration times ordered by the Neurologist. Findings included: 1. Resident #1 admitted to the facility 11/13/2019 with diagnose of heart failure, pulmonary disease, and diabetes. The most recent Quarterly Minimum Data (MDS) assessment dated 7/1/2020 revealed Resident #1 was cognitively intact, and she received diuretics for 7 of 7 days during the assessment. A Physician's Order for Potassium Chloride 20 milliequivalents by mouth one time a day for supplement for hypokalemia was written 2/9/2020. Resident #1's Medication Administration Record was reviewed and Potassium Chloride 20	F 760	F-Tag 760 1. Residents #1, #14 and #18 have had their medications reviewed by the Director of Nursing on 7/28/20 and appropriate action taken. 2. All resident have the potential to be affected. A review of all missed medications has been completed by the Director of Nursing from the past 30 days 3. Education was completed on 8/20/20 by the Director of Nursing for all licensed staff on the process of medication errors and on 8/14/20 on medication administration. New hire and contract staff will receive education prior to working on the floor. 4. The Director of Nursing and /or designee will randomly audit 5 residents weekly to ensure timely and appropriate medication administration for 4 weeks, and then 5 random charts monthly for 2 months. This audit will also include in its audit the timestamp of medication administration documentation. The Administrator will present results of the audits to the Quality Assurance Performance Committee monthly for 3 months. The QAPI committee can modify this plan to ensure the facility remains in compliance	

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F 760	Continued From page 64	F 760		

milliequivalents was not documented as given 7/8/2020, 7/15/2020, 7/17/2020, 7/19/2020, 7/20/2020, 7/21/2020 or 7/22/2020.

A Nurse's Progress Note dated 7/8/2020 at 9:49 am written by Nurse #1 stated Resident #1's Potassium Chloride Supplement was not available and was ordered from the pharmacy and the nurse was waiting for arrival of the medication.

Review of a Nurse's Progress Note dated 7/15/2020 at 9:51 am written by Nurse #2 revealed the dose of Potassium Chloride was not available.

On 7/17/2020 at 9:41 am the Nurse's Progress Note written by Nurse #2 stated the dose of Potassium Chloride was missed.

A Nurse's Progress Note dated 7/20/2020 at 9:52 pm written by Nurse #2 revealed the dose of Potassium Chloride was not available.

On 7/22/2020 at 9:47 am a Nurse's Progress Note dated 7/22/2020 written by Nurse #4 stated she had reordered the Potassium Chloride from the pharmacy because it was unavailable.

A Physician's Progress note dated 7/21/2020 at 3:10 pm stated Resident #1 told the Physician she had not received ordered medication. The medication was Potassium Chloride and the note further stated Nurse #3 told the Physician the medication was reordered that morning. The Physician's Progress Note also stated Resident #1 was a long-term resident due to heart failure and kidney disease.

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A Nurse's Progress Note dated 7/22/2020 at 9:47 by Nurse #4 revealed she had reordered Resident #1's Potassium Chloride from the pharmacy because the medication was unavailable.

During an interview with Nurse #4 on 7/27/2020 at 11:15 am she stated she worked for an agency but had taken care of Resident #1 for one week. Nurse #4 stated she had issues with getting Resident #1's Potassium Chloride from the pharmacy and it had taken her 24 hours to get the medication and she had missed giving the dose on 7/22/2020.

An interview was conducted with Resident #1 on 7/28/2020 at 9:50 am. She stated she had missed several doses of her Potassium Chloride in July 2020 and was concerned.

An interview with Nurse #1 on 7/28/2020 at 11:10 am revealed she had worked at the facility in April 2020 and the first week of July 2020 and had cared for Resident #1. Nurse #1 stated there were several medications that were not available for different residents when she worked at the facility. She stated she kept ordering the missing medications from the pharmacy when she could not find a medication. Nurse #1 stated she remembered Resident #1's Potassium was missing, and she had ordered it from the pharmacy, and she did miss administering the dose on 7/8/2020 because it was not available.

During an interview with Nurse #2 on 7/28/2020 at 11:32 am she stated she remembered Resident #1 and had reordered her Potassium Chloride several times and remembered she could not give it because it was not available on

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7/15/2020, 7/17/2020, 7/19/2020 and 7/20/2020.

An interview was conducted with Nurse #4 on 7/28/2020 at 11:39 am and she stated she had been assigned to Resident #1 and was not able to give her Potassium Chloride on 7/22/2020 because the medication was not available.

During an interview with Nurse Practitioner #1 on 7/30/2020 at 11:45 am she stated she was not made aware of Resident #1's Potassium Chloride not being available 7/8/2020, 7/15/2020, 7/17/2020, 7/19/2020, 7/20/2020 and 7/21/2020. Nurse Practitioner #1 stated Resident #1 was prescribed a diuretic and not receiving the Potassium Chloride could have potentially caused her harm. She stated the diuretic could have lowered Resident #1's Potassium levels without the Potassium Chloride supplement which could have led to an abnormal heart rhythm.

An interview with the Physician on 8/3/2020 at 9:38 am revealed he was not notified Resident #1 had missed doses of Potassium Chloride on 7/8/2020, 7/15/2020, 7/17/2020, 7/19/2020, 7/20/2020 and 7/21/2020. The Physician stated Resident #1 was on a diuretic and decreased Potassium levels could lead to an abnormal heart rhythm. He stated Resident #1 did not have an episode of hypokalemia and she did not complain of symptoms of hypokalemia.

On 8/4/2020 at 4:36 pm an interview was conducted with the Pharmacist and she stated the facility received Resident #1's Potassium Chloride (30 doses) on 5/26/2020 and then again on 7/22/2020. The Pharmacist stated the facility had not ordered enough Potassium Chloride supplements to have enough doses to administer

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the drug through 7/2020. The Pharmacist stated the pharmacy does not automatically send the dose of Potassium Chloride and the nurses should have ordered the medication by sending a faxed request form. The Pharmacist stated the pharmacy received the faxed request form on 5/26/2020 and 7/22/2020.

2. Resident #14 admitted to the facility on 9/19/2015. Her diagnoses include chronic kidney disease and heart disease.

A Quarterly Minimum Data Set (MDS) Assessment dated 7/1/2020 revealed Resident #14 was cognitively intact and had a diuretic for 7 of 7 days of the look back period.

A review of Resident #14's Medication Administration Record for April 2020 revealed doses not documented as given of Propafenone Extended Release 325 milligrams two times a day on 4/10/2020 for the 9:00 am dose and the 9:00 pm doses. Propafenone is a drug used to treat and prevent Resident #14's irregular heart rhythm.

The review of the April 2020 Medication Administration Record for April 2020 revealed Resident #14 had not received Hydrochlorothiazide 50 mg ordered three times a day on 4/7/2020 at 9:00 pm; 4/8/2020 at 9:00 am, 2:00 pm, or 9:00 pm; 4/9/2020 at 9:00 am or 2:00 pm; and on 4/11/2020 at 2:00 pm.

During an interview with the Director of Nursing on 7/29/2020 at 12:15 pm she stated she was not made aware Resident #14 had missed doses of medication during April 2020. The Director of Nursing stated the medications should have been

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given as ordered by the physician and if the medication was not available the physician and the pharmacy should have been notified.

During an interview with Nurse #9 on 7/31/2020 at 2:31 pm she stated she had worked on 4/7/2020 on the 3:00 pm to 11:00 pm shift. Nurse #9 stated she would have given Resident #14 her 9:00 pm dose of Hydrochlorothiazide 50 mg on 4/7/2020 if it was available, she stated the medication was not available and she had marked it as not given.

An interview with Nurse # 7 on 8/3/2020 at 11:05 am she stated she had worked at the facility on 4/1/2020 but she did not remember Resident #14. She stated if she documented she did not give Resident #14 her medication it was because it was not available. She stated she would have called the physician to notify him it was not available too. Nurse #7 stated she did remember the facility did have missing medications and she had to call the pharmacy frequently.

During an interview with Nurse #6 on 8/3/2020 at 2:40 pm she stated she did not have Resident #14's Hydrochlorothiazide 50 milligrams available on 4/8/2020 for the 9:00 am and 2:00 pm doses. She stated she had ordered if from the pharmacy but did not have it available. Nurse #5 stated although there was an order to substitute Resident #14 had refused the Guaifenesin 30 milliliters liquid when the Guaifenesin 600 mg tablets were not available.

An interview with Nurse #8 on 8/3/2020 at 3:24 pm revealed she had worked at the facility on 4/8/2020. She stated she had not returned to the facility after that evening shift. She stated she did

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not remember Resident #14, but she had several missing medications that night. Nurse #8 stated she had notified the Unit Manager but did not remember the name of the Unit Manager she had medications that were unavailable. Nurse #8 stated she had notified the pharmacy of all the medications she did not have available and she had documented on each resident's record the medication had not been given.

During an interview with the Administrator on 8/3/2020 at 4:20 pm she stated the nurses should have given Resident #14's medication as ordered and followed the facilities policy.

3. Resident #18 admitted to the facility on 4/8/2019 with diagnosis of Parkinson's Disease.

A Quarterly Minimum Data Set (MDS) Assessment dated 5/8/2020 revealed Resident #18 was cognitively intact.

A Physician's Order dated 7/13/2020 from the Neurologist for Carbidopa/Levodopa 25/100 milligrams stated it is medically necessary and important to follow dosing times daily for Resident #18's Parkinson's Disease management.

On 7/22/2020 the Physician ordered Carbidopa-Levodopa 25/100 milligrams give 1 tablet at 6:00 am and 2 tablets at 9:00 am, 12:00 pm, 5:00 pm and 9:00 pm for Parkinson's Disease.

During an observation and interview with Resident #18 on 7/28/2020 at 4:16 pm she stated if she did not get her Parkinson's Medication (Carbidopa/Levodopa) on time each day she has difficulty moving. Resident #18 stated there were

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F 760	Continued From page 70	F 760		

many times she did not get her medication within one hour of the time it was ordered, and she had difficulty moving and sitting up in her chair when her medication was given later than ordered.

An interview was conducted with Resident #18's Neurologist on 7/29/2020 at 10:30 am and he stated if her Parkinson's Medication (Carbidopa/Levodopa) was given more than one hour after it was due it would be harmful. He stated Resident #18 would not be able to move as well.

During an interview with the Director of Nursing on 7/29/2020 at 12:15 pm she stated she was not made aware Resident #18 had not received her Parkinson's Disease medication within one hour of the set administration time. She stated the facility had recently divided the 200 Hall into two assignments due to the nurses not being able to complete their medication administration passes within a reasonable time. The Director of Nursing stated the physician should be notified by the nurse when a medication is not given according to the physician's order.

During an interview on 7/30/2020 at 10:23 am with Nurse #6 revealed she worked at the facility on 5/24/2020 and she stated she had given Resident #18 her Parkinson's Medication late. Nurse #6 stated there were so many residents on that unit it was impossible for the nurse to give the medications on time.

An interview was conducted with Nurse #10 on 7/30/2020 at 10:38 am. Nurse #10 stated she had worked the evening shift on 5/24/2020 and she had given Resident #18's medications late because there were almost 40 residents on the

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F 760	Continued From page 71	F 760		

assignment, and it was impossible to give the medications within an hour of the scheduled time.

Nurse #11 was interviewed on 7/30/2020 at 11:08 am she stated she had cared for Resident #18 on several evening shifts in July and she had not given her Parkinson's Disease medication within one hour of the medication being due. Nurse #11 stated the assignment consisted of almost to many residents and it was impossible to give Resident #18's medication within one hour of it being due.

During an interview with Nurse #1 on 7/30/2020 at 11:21 am she stated she had worked on 7/8/2020 and was late giving Resident #18 her medications. Nurse #1 stated there were so many residents on the assignment she was not able to give the Parkinson's Disease medication within one hour of the time it was due.

On 7/30/2020 an interview with the Nurse Practitioner #1 revealed Resident #18's Parkinson's Disease medication being administered late could be harmful. The Nurse Practitioner #1 stated the Carbidopa/Levodopa later than one hour after it was due could cause Resident #18 to increased tremors and could have led to a fall.

The Physician was interviewed on 8/3/2020 and he stated he was not notified of Resident #18 did not receive a notification Resident #18's Carbidopa/Levodopa was not being administer within one hour of the ordered time. He stated giving Carbidopa/Levodopa to far apart would result in Resident #18 "freezing up" or not being able to move. He further stated if the doses were given to close together it could cause

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F 760	Continued From page 72 hallucinations and confusion. The Physician stated Resident #18's Parkinson's Disease was stable, and she had not complained of any worsening of her symptoms.	F 760		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on a test tray observation, Resident Council meeting minutes (February - July, 2020), interviews with 3 residents (Residents #23, #26 and #10), staff interviews and review of medical records, the facility failed to provide foods per resident preference for taste and temperature. The findings included: 1a. Resident #23 was admitted to the facility on 6/17/15. Diagnoses included iron deficiency anemia, gastroesophageal reflux disease, peritoneal abscess, acute gastritis with bleeding, and vitamin D deficiency, among others. A quarterly Minimum Data Set (MDS) assessment, dated 7/15/20 assessed Resident #23 with intact cognition, clear speech, able to understand and be understood, and independent with eating after staff assistance with set up. Resident #23 had a physician's order for a regular diet with regular	F 804	F-Tag 804 1. The resident concerns regarding temperature and palatability of food has been address by the Regional Director of Food Service on 8/14/20 2. The Food Service Manager has been re-educated by the Regional Director of Food Service on palatability and food temperatures on 8/14/20 3. All Dietary staff have been educated on food temperature and palatability by the Regional Director of Food Services on 8/14/20 4. The Food Service manager will perform 5 test trays weekly for the next 3 months and report findings to the QAPI committee for review and recommendation. The Administrator will present results of the audits to the Quality Assurance Performance Committee	9/22/20

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F 804	Continued From page 73 texture. During an interview and observation of the lunch meal on 7/29/30 at 1:00 PM, Resident #23 stated meats were often tough and grits were hard/cold. She had expressed these concerns during Resident Council meetings, but stated, "It was like talking to a brick wall." 1b. Resident #26 was admitted to the facility on 3/6/19. Diagnoses included type 2 diabetes mellitus, hyperlipidemia, hypertension and hypokalemia, among others. A quarterly MDS assessment dated 7/3/20 assessed Resident #26 with intact cognition, clear speech, able to understand and be understood, and staff supervision with meals after set up. Resident #26 had a physician's order for a regular diet, regular texture. An interview occurred with Resident #26 on 7/30/30 at 4:40 PM. Resident #26 stated that she had expressed during Resident Council Meetings that the food was not good, especially the supper meal. She stated taco shells were like dough. 1c. Resident #10 was admitted to the facility on 12/17/15. Diagnoses included type 2 diabetes mellitus, protein calorie malnutrition, hyperlipidemia, hypertension, vitamin D deficiency and Alzheimer's dementia, among others. A quarterly MDS dated 7/2/2020 assessed Resident #10 with mildly impaired cognition, able to understand and be understood, and independent with meals after staff assistance with set up. Resident #10 had a physician's order for a regular diet, regular consistency and double portions with all meals.	F 804	monthly for 3 months. The QAPI committee can modify this plan to ensure the facility remains in compliance.	

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Resident #10 was observed with her lunch meal on 7/29/20 at 12:45 PM. During the observation, Resident #10 stated her lunch that day was "fair", but since January 2020, she had routinely received foods that were cold and undercooked which she expressed during Resident Council meetings.

2. Review of Resident Council meeting minutes February 2020 - July 2020, revealed residents expressed the following dietary concerns:
- Hot plates were used for meals, but the food was still cold. This was expressed by 8 residents during the 2/9/20 meeting, and by 14 residents during the 3/6/20 meeting. The follow up was dietary staff re-education and to complete dish washing earlier in the shift to allow more time for plates to heat properly.
- Condiments (creamer, salt, pepper) were not available on meal trays to season foods. This was expressed by 6 residents during the 4/3/20 meeting, the 5/14/20 meeting and the 7/24/20 meeting. Follow up included staff re-education; monitoring and the addition of a food committee to address food concerns.

The Dietary Manager (DM) was interviewed on 7/30/20 at 12:15 PM. She stated she was aware of dietary concerns expressed during Resident Council meetings regarding cold foods, variety and condiments. The DM stated that a Food Committee was started July 2020 to help address these concerns, but that she was still working on resolutions to these concerns. The DM stated that she used to conduct tray audits to identify concerns with tray accuracy, but that she had not completed an audit since June 2020.

The Corporate Food Service Director (FSD) was

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F 804	Continued From page 75	F 804		

interviewed on 7/30/20 at 1:00 PM. She stated that she completed sanitation audits on her last 2 visits (May 2020 and June 2020) with some concerns noted and conducted a test tray audit in May 2020 with no concerns noted. She stated the DM addressed some things identified during the audits, but that she was still working to resolve come concerns.

The Administrator stated in interview on 7/30/20 at 1:30 PM that she reviewed Resident Council meeting minutes and she was aware of the dietary concerns residents had expressed regarding cold foods and condiments. She stated these concerns were addressed by the DM with re-education, monitoring/audits, and that an additional Resident Council meeting was held in July 2020 because residents continued to say that dietary concerns were not resolved. The Administrator stated the additional July 2020 meeting was held to give more opportunity for residents to voice concerns and see if the changes made were working.

3. A lunch meal test tray observation occurred on 7/30/20. A regular diet test tray (meatloaf, mashed potatoes, greens, roll, iced tea and apple crisp) was requested at 12:45 PM, the tray was placed on an open metal delivery cart by staff. Staff exited the kitchen with the test tray at 12:50 PM and arrived on the 300 hall at 12:52 PM. All residents were served and/or assisted with their meals by 1:09 PM and the test tray was sampled by the DM and surveyor. The test tray observation had the following results:
- The margarine did not melt when added to the mashed potatoes and greens but remained congealed. There was no visible steam. The DM agreed that the mashed potatoes and greens

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F 804	Continued From page 76 were bland in taste and were not hot. - The ice in the tea had melted and was cool The DM stated during the observation that the census on the 300 hall had been low, but recently increased. She stated she had 4 metal enclosed carts available for use, but that she had not been using an enclosed cart on halls where the census was low. Since there were more residents now on the 300 hall, the DM stated she would instruct dietary staff to start using the enclosed metal carts, rather than an open cart for meal delivery to all halls where the census had increased. She expressed this change would help to keep foods hotter longer.	F 804		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and review of the medical record, the facility failed to honor food allergies and preferences for 1 of 3 sampled residents (Resident #2). The findings included:	F 806	F806 1. Resident #2 has had the dietary tray card updated per preferences by the Dietary Manager 7/31/20□ 2. The Dietary Manager reviewed completed an audit on all residents with no further issues noted. 3. The Dietary Manager has received	9/22/20

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F 806	Continued From page 77 Resident #2 was admitted to the facility on 2/28/20 and re-admitted on 5/12/20. Diagnoses included type 2 diabetes mellitus, anemia and edema, among others. An admission Minimum Data Set (MDS), dated 3/6/20 and a quarterly MDS dated 6/5/20 both assessed Resident #2 with intact cognition, adequate vision, clear speech, able to understand and be understood, and independent with eating after staff assistance with set up. Review of her medical record revealed a physician's order dated 3/20/20 which documented Resident #2 was allergic to fish, tomatoes and oranges. A care plan for Resident #2, revised April 2020, identified a nutrition risk for malnutrition and dehydration. Interventions included to honor food preferences as available, obtain likes, dislikes and allergies. The care plan documented Resident #2 was allergic to orange juice. Resident #2 was observed eating lunch on 7/29/20 at 1:50 PM and eating breakfast on 7/30/30 at 8:33 AM with a glass of orange juice on her overbed table. She stated during the observation that she received orange juice every morning, but that she was allergic to it and could not have it. She stated that by the time she realized she had received it the staff had already left the room, so she did not get a chance to ask for something else. She expressed she had brought this to staff 's attention several times. Review of her diet order card revealed an allergy to oranges was not recorded. An interview with the Dietary Manager (DM)	F 806	education from the Regional Dietary Manager on honoring preferences and ensuring allergies are on the tray cards. 4. The Dietary Manager and / or designee will randomly audit 5 tray cards per week for accuracy, for preferences, and for allergies for one month. Then 5 tray cards monthly for 2 months. F-Tag 812The Administrator will present results of the audits to the Quality Assurance Performance Committee monthly for 3 months. The QAPI committee can modify this plan to ensure the facility remains in compliance	

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F 806	Continued From page 78 occurred on 7/30/30 at 12:15 PM and revealed that Resident #2 had expressed in the past concerns with receiving foods she was allergic to, but the DM stated that she thought this concern had been resolved. The DM also stated that the tray card for Resident #2 did not record her allergy to oranges which was an oversight and the reason Resident #2 had continued to receive orange juice on her breakfast tray. The DM stated that she was made aware of the error that morning (7/30/20) and as a result she updated the tray card for Resident #2 to include her allergy to oranges. The DM stated that she used to monitor for tray line accuracy with tray audits, but got away from conducting these audits. The DM further stated that her last audit was done in June 2020 and that she would resume these audits to address recent dietary concerns.	F 806		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and	F 812		9/22/20

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F 812	Continued From page 79 serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and review of facility records, the facility failed to store bananas per manufacturer recommendations to reduce signs of spoilage and implement an effective cleaning and repair schedule for 7 months (December 2019 - July 2020). The findings included: 1. A kitchen observation occurred on 7/29/20 at 11:50 AM. During the observation bananas were observed stored on the lower shelf of the cook's prep table stored in a cardboard box. The bananas were observed with dark spots throughout. Manufacturer instructions for storage were included on the box and recorded to store the bananas at a temperature of 58 degrees Fahrenheit (F) or less. An interview with the Maintenance Director occurred on 7/29/20 at 4:29 PM and revealed the ambient temperature in the kitchen was 85 degrees F. An interview with the Dietary Manager (DM) occurred on 7/29/20 at 12:15 PM and revealed that the kitchen stayed pretty hot, but that she did not use a temperature gage to monitor the ambient temperature in the kitchen or dry storage. The DM also stated that bananas were typically stored on the lower shelf of the cook's prep table. She stated that the bananas expired quickly, but that she did not store bananas in refrigeration because the banana peel turned black. The DM expressed that she recently	F 812	F-Tag 812 1. The bananas were moved to the storage area on 7/29/20. Previous recommendations made through sanitations audits have been addressed. 2. All residents have the potential to be affected. The Corporate Food Service Director audited the kitchen to ensure all food is being stored appropriately and cleaning schedule implemented and maintained. 3. All dietary staff have been educated on the appropriate procedure for food storage on 8/14/20 by the Food Service Manager. The Food Service Manager educated staff regarding routine cleaning schedule and preventative maintenance schedule on 8/14/20 4. The Food Service Manager and /or designee will randomly audit food storage 5x□s weekly 4 weeks, and then 5 random charts monthly for 2 months the Food Service Manager will utilize the monthly cleaning schedule as an audits to ensure a clean and sanitary environment. This will be reviewed weekly by the Administrator and /or designee for the next 12 weeks. The Administrator will present results of the audits to the Quality Assurance Performance Committee monthly for 3 months. The QAPI committee can modify this plan to ensure the facility remains in compliance.	

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F 812	Continued From page 80	F 812		

started ordering a smaller quantity to prevent spoilage.

2. A kitchen observation occurred on 7/29/20 from 11:50 AM to 12:15 PM. The following concerns were noted regarding sanitation:
- The perimeter of the kitchen floor was noted with dark colored debris, food particles, and paper
- The three ovens were noted with a thick black debris buildup and the oil in the deep fryer was dark/discolored
- The lower shelves and legs of the cook's prep stations were noted with dark debris buildup
- The conveyor belt of the tray line was noted with dried food debris and dark colored buildup
- Multiple broken floor tiles were noted along the perimeter of the wall and in the dish machine area
- Three floor tiles were concaved in the dish machine area
- Approximately 2- inch hole was noted in the wall next to the power switch for dish machine

Review of the following documents recorded concerns with kitchen sanitation:
- Pest Service Vendor reports:
o 3/5/20, floor tiles and baseboards tiles loose/missing, floor drains in need of cleaning
o 4/2/20, paint peeling along wall behind dish machine, wheel casters for the plate warmer and buffet line need cleaning, floor tiles and baseboards loose/missing, floor drains in need of cleaning
o 7/19/20, floor tiles on baseboards missing/broken, grease build up in/behind dish machine, floor drains in need of cleaning

- Health Department Sanitation Inspection:

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F 812	Continued From page 81 o 12/9/19, The kitchen and door frames need to be painted, there is lots of loose, flaking and peeling paint in the kitchen - Corporate Sanitation Audit: o 5/29/20, Seasonings out dated, shelf dirty, tiles broken in dish area; stove/oven/deep fryer dirty; toaster tray rusty, paint peeling; plate warmer needs bottom wiped out; ceiling vents need to be cleaned o 6/16/20, Missing and broken tile in dish room, oven under stove needs detail cleaning, schedule cleaning for drain in floor, schedule detail cleaning in dish room Review of the June and July 2020 Cleaning Schedules, revealed the following: - June 1 - 7, 2020 no documentation of cleaning for the bottom shelves, table legs, beverage station, can opener, top oven, bottom oven, or stove - June 8 -14, no documentation of cleaning for the refrigerator, moping stock room, conveyor of the tray line, bottom oven, or stove - June 15 - 21, 2020, no documentation of cleaning the bottom shelves, beverage station, hot pellet warmer, steamer, or coffee machine - July 1 - 18, 2020, no records were available to review - July 19 - 25, 2020 no documentation of cleaning the reach in refrigerator, steam table, steamer, ice machine, microwave, dish machine, dish room, kitchen floor, top oven, bottom oven, stove oven, condiment holders, coffee machine, and condiment station An interview with the Maintenance Director occurred on 7/30/20 at 11:50 AM. He stated that he was new to this role for the past 2 weeks and	F 812		

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F 812	Continued From page 82	F 812		

he assisted the prior director to complete repairs in the dietary department. He stated that he had previously grouted around the floor and baseboards, but did not replace the broken tiles. He also stated he had not reviewed all of the Pest Service Vendor reports or the Health Department Inspection, but that he was aware of the recommendations made by Pest Service Vendor at the 7/19/20 visit. He further stated that he had not had opportunity to address the concerns. He stated he came into the dietary department once weekly for the last 2 weeks to monitor dish machine temperatures, but he did not look to see if any repairs were needed.

The Dietary Manager (DM) was interviewed on 7/30/20 at 12:15 PM. She stated that monitored staff regarding implementing the cleaning schedule, but that she was out in April 2020 and "We got behind on some of the cleaning." The DM stated that the staff last deep cleaned ovens in May 2020, and staff did not get to clean the ovens in June 2020. She also stated that the Corporate Food Service Director (FSD) completed Sanitation Inspections and made her aware of the findings.

The FSD was interviewed on 7/30/20 at 1:00 PM. She stated that she completed sanitation audits on her last 2 visits (May 2020 and June 2020) with some concerns noted. She stated the DM addressed some things identified during the audits, but that she was still working to resolve come concerns.

An interview with the Administrator occurred on 7/30/20 at 1:30 PM and revealed she expected dietary concerns to be addressed by management with staff re-education, monitoring

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F 812	Continued From page 83 and audits. The Administrator also stated she expected foods to be stored according to manufacturer recommendations.	F 812		
F 880 SS=K	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections 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	F 880		9/29/20

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F 880	Continued From page 84 reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §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, staff interviews, Nurse Practitioner and physician interviews the facility failed to follow the Centers for Disease and Prevention (CDC) guidelines requiring staff to wear a mask covering the mouth and nose in long term care settings for 11 of 22 staff	F 880	F-Tag 880 1. Resident #27 has received a new glucometer on 8/ 19/20. Nurse #5 was educated by the Director of Nursing on 8/22/20 on Glucometer use and cleaning. Due to the fluid nature of the COVID 19	

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F 880	Continued From page 85 members (Director of Nursing #1, Director of Nursing #2, Social Worker #2, Nurse #2, Nurse #14, Admission Coordinator, Receptionist #3, Cook #1, Staff Development Nurse, Medication Technician #2, and Nurse Aide #10) observed on the 200 and 500 hallways and nursing desks, the kitchen and the front lobby area with staff and residents within 6 feet of each other. In addition the facility failed to clean and disinfect a shared glucometer (a device used to check blood sugars) before and after use, according to the manufacturer's recommendations, when checking the blood sugars of 1 of 4 sampled residents observed for blood sugar checks (Resident #27). Immediate Jeopardy began on 07/27/20 when observations were made of the Director of Nursing (DON) #1 walking down the hall from the front of the building to the office, past a resident and then went behind the nursing station with her mask below her nose, and observations throughout the survey of other direct care staff and administrative staff that failed to wear the mask correctly covering the nose and mouth during the COVID-19 pandemic. Immediate Jeopardy was removed on 08/26/20 when the facility implemented a credible allegation of Immediate Jeopardy removal during an on-site validation conducted on 9/1/20. The facility remains out of compliance at a lower level and scope of severity of E (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to update their policy/plan, complete employee education and ensure monitoring systems in place are effective. The facility also was not in compliance with disinfection of the blood glucose meter. This was cited at a lower scope and severity of D.	F 880	outbreak Accordius Health drafted a Policy/Plan which is updated as guidance and recommendations change and to as the latest guidance is available to each facility. The Accordius Health COVID 19 Task Force provides updated guidance, in line with CDC and CMS changes, as they occur. As changes are made to the COVID 19 plan, this information is then properly communicated to staff from each department. The Accordius Health COVID 19 Update will be printed by the administrator or the receptionist and provided to all employees or contract workers upon entrance each shift/day. 2. Current resident with a sliding scale insulin have received personal glucometers. All residents are at risk from the failure to adhere to correct and adequate infection control processes. All 24 residents requiring regular blood sugar check have been provided with their own personal glucometers. As staff sign into the facility and are given a copy of any updates to the COVID 19 plan they will sign a log indicating they understand the content of the information in the plan. This log will be reconciled with the sign log by the supervisor daily to ensure all staff on duty have signed for a copy of our COVID 19 plan updates and understand the content. 3. All licensed staff have been educated by the Director of Nursing on proper cleaning of the glucometer on 8/20/20. All new hires and contract staff will receive this education prior to working the floor	

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F 880	Continued From page 86 The findings included: 1.According to the facility protocol document titled "COVID Plan" updated June 2020, all staff that come into direct contact with residents or resident environment were to wear masks. CDC Guidelines were referenced as a resource in the plan. According to the CDC Guidelines updated June 2020 all Healthcare Personnel (HCP) should wear masks while in the facility. HCP included persons not directly involved in patient care, but who could be exposed to infectious agents that can be transmitted in the healthcare setting (e.g .... clerical, administrative and billing). A. On 07/27/2020 at 11:18 AM DON #1 was observed walking down toward the resident's 200 hall from the front of the building to the office, past a resident and went behind the nursing station with her mask below her nose. B. An observation was made 07/28/20 at 5:30 PM of DON #1 with the mask below her nose during an interview at the medication cart on the 200 hall, there were no staff or residents within six feet. An interview was completed with DON #1 on 07/28/20 at 5:24 PM about the requirements for mask use during the COVID 19 pandemic. She stated the expectation was for all staff to wear masks when they were in the building and wear it over their mouth and nose. She said some masks fell down, and if they saw this and it was not covering the mouth and nose, they told staff to pull it up. She acknowledged that her mask kept falling down below her nose especially when she	F 880	The Nursing Home Administrator and/ or Director of Nursing re-educated all staff, from all departments, on the COVID 19 Policy/Plan on 8/26/20. This plan requires wearing a surgical mask, provided by the facility, while in the facility. Anyone not re-educated on 8/26/20 will not be allowed to work until reeducation is completed. The in-service also included proper donning and doffing of masks, the importance of not touching the body of the mask at any time, the requirement to keep the mask clean and in place at all times, as well as methods of preserving the integrity and cleanliness of the mask. Staff have been instructed that if their mask do not stay up on their nose and cover their mouth that they should see their supervisor to obtain a new mask per CDC and CMS guidelines The facility has designated 1 entrance/exit into the building. A staff member will monitor the entrance throughout the 3 shifts. Upon entrance to the facility, the staff member will instruct the employee on proper use of wearing the mask at all times and to ensure they are covering their mouth and nose. 4. The Director of Nursing and /or designee will randomly audit 5 x□s weekly to ensure appropriate glucometer use and cleaning 4 weeks, and then 5 random charts monthly for 2 months The Director of Nursing and/ or designee will randomly audit all three shifts 5x□s per week to ensure proper infection control measures are in place for the next 3 months The Administrator and /or designee will	

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F 880	Continued From page 87 spoke, and she would pull it back over her nose during the interview. The Assistant Director of Nursing was interviewed on 7/28/20 at 6:44 PM regarding the requirements for staff wearing masks during the COVID 19 pandemic. She stated staff must put a mask on when in the building. Masks were to be worn across the nose and mouth. She said there were no issues with the masks staying on the face that she was aware of and the facility had different types of masks that could be worn. C. On 08/04/20 at 12:10 PM a continuous observation was conducted of the Admission Representative, who was at the front lobby desk not wearing a mask. She was talking with the Administrator behind the desk while employee and surveyor screenings were also being done at the lobby desk that was less than 6 feet away from where they were talking. The Admission Representative was screening and interacting with employees and surveyors who entered the facility by giving instructions on temperature taking and the regulatory screening questions. She did not have a mask on and was within 6 feet of a surveyor who was completing the pre-screen temperature and questionnaire. An interview was conducted on 08/21/20 at 8:43 AM with the Admission Representative. She stated administration had been asked about the need for masks in the front lobby and front offices multiple times. They were told masks were not required in the front lobby area or in the front offices by the administrator. She stated she shared an office with another person, but they were more than 6 feet apart. They were instructed to wear masks in meetings, if multiple	F 880	randomly audit staff to ensure proper usage of PPE 5x□s weekly across all three shifts for 12 weeks. The Administrator will present results of the audits to the Quality Assurance Performance Committee monthly for 3 months. The QAPI committee can modify this plan to ensure the facility remains in compliance.	

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people were in an office and not 6 feet apart, or if they went past the door toward the resident's hallway.

An interview was conducted with the Nurse Practitioner (NP) on 07/29/20 at 11:25 AM. The NP stated staff should be wearing a face mask and they should be covering the mouth and the nose to prevent COVID 19 from spreading.

The Medical Director was interviewed on 07/30/20 at 2:28 PM and stated staff should be wearing the masks over the mouth and the nose for COVID 19 precautions to be in place.

Receptionist #1 was interviewed on 08/04/20 at 9:57 AM regarding PPE that was required during the COVID 19 pandemic. She stated all staff must wear masks and gowns, face shields as needed, and shoe covers when available. She stated they usually had different masks they can choose from. She said she was told staff at the front desk don't need to wear masks, as they were not normally close enough to residents and needed to wear them if they go back to the resident's hallway. She stated they were supposed to wear a mask if they answered the front door.

D. On 08/04/20 at 12:22 PM Nurse #2 was observed at the medication cart on the 200 hall with the entire mask around her neck, and her mouth and nose were uncovered. She was talking with a resident who was wearing a mask and standing at the cart at a distance less than 3 feet. The nurse gave this resident an oral medication and proceeded to give him a subcutaneous injection. The nurse then gave the resident a hug. The nurse moved her mask up

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over her mouth after this, when she saw the surveyor, however her nose was still exposed.

Additional observations were made of Nurse #2 on 08/04/20 at 1:15 PM at the nursing unit desk with the mask at her neck and at 2:25 PM at the nursing unit desk with the mask at her mouth.

Numerous calls with messages left were attempted to interview Nurse #2 (agency) without success.

E. An observation was completed on 08/04/20 at 1:25 PM of the Admission Representative, and Social Worker (SW) #2 both engaged in conversation within 3 feet of each other at the lobby desk, neither staff members had face masks on.

The Administrator was interviewed at 2:50 PM on 08/4/20. She stated the policy for wearing masks was that they should be worn on the nursing units, and for the receptionists if they were at a 6-foot distance, the receptionists didn't need to wear a mask unless they were in a meeting.

F. An observation was completed on 08/05/20 at 2:09 PM of Receptionist #2 without a mask on and Resident #29 with a mask on, at her desk in the lobby, less than 6 feet apart.

An interview was done with Receptionist #2 on 08/03/20 at 5:11 PM. She stated that they don't wear a mask at the front desk but would put one on if they went down the hall toward the nursing unit. She further stated the residents and staff were usually not within 6 feet of her at the desk.

G. An observation was made on 08/14/20 at 9:20

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AM of SW #2 with a mask only covering her mouth and Receptionist #3 with her mask only covering her mouth at the reception desk. There were 2 surveyors with masks on checking in, at the desk area with SW #2 and Receptionist #3.

An interview with SW #2 was conducted on 08/21/20 at 9:58 AM about the mask policy. She stated the Administrator had told the staff they did not need to wear the mask in the front of the building, including the lobby, even if the residents were present. She stated they were told to wear masks in meetings.

H. Observations were completed on 08/14/20 of Receptionist #3 at 10:31 AM AND 12:16 pm with her mask below her nose at the front lobby desk.

An interview was conducted with Receptionist #3 on 08/21/20 at 8:39 AM. She stated that she had been instructed by the Administrator they did not need to wear a mask, only if a resident came up to the front lobby or if they went into the hall leading to the resident's area. She stated if they wore a mask, it should cover the mouth and the nose.

I. Observations of DON #2 were made on 08/14/20 at 11:26 AM and 3:48 PM standing at the medication cart in the 200 hallway with her mask only covering her mouth.

An interview with DON #2 was conducted on 8/18/20 at 10:26 AM. She stated masks were to be worn at all times upon entry to the building, unless they were alone in a private office. She stated if others enter the office and were within 6 feet in the office the masks should be on. The mask should cover the nose and the mouth and

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fit snugly.

J. An observation was made of Nurse #14 on 08/14/20 at 3:40 PM. She was sitting at the desk with her mask off, and her mask was lying on the desk. She placed the mask on upon seeing the surveyor. A resident was sitting behind the desk next to the nurse with her mask below her mouth and within 3 feet of the nurse.

An interview was completed on 08/25/20 at 2:07 PM with Nurse #14 about the protocol for wearing masks. She stated masks were to be worn at all times in patient care areas. When asked about the observation from 08/14/20 when her mask was off and lying on the desk, she stated she was not able to breath with the mask on.

On 08/25/20 at 1:30 PM Cook #1 was observed in the kitchen area working with resident trays and other staff within 6 feet with her mask only covering her mouth.

An interview was completed with Cook #1 on 08/25/20 at 1:31 PM, when questioned about the requirements for masks, she stated that masks were to be worn at all times and cover the mouth and nose. She said the mask would slip down from her nose frequently and she had to keep pulling it up.

K. An observation was completed on 08/25/20 at 2:01 PM of the Staff Development Nurse with the mask below her nose in her office across from the 500-600 hall nursing desk.
A new employee, Medication Technician (Med Tech) #2 that had started work on 08/25/20 was seated beside her at the same desk with her mask covering her nose and mouth.

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An interview was conducted on 08/25/20 at 2:02 PM and the Staff Development Nurse stated masks should cover the nose and mouth, however her mask kept sliding down. She acknowledged that masks should be worn at all times in the building.

L. An observation was conducted on 03/25/20 at 3:14 PM in the front lobby as NA #10 entered from the resident hallway without a mask and was conversing with other staff that were being screened before their shift, within 6 feet of them for 3 minutes.

An interview was conducted with NA #10 at 3:17 PM about the mask protocol. She stated she was educated on mask usage and that masks were always to be worn and social distancing of 6 feet was required.

The Administrator was notified via phone at 4:48 PM that the facility was placed in Immediate Jeopardy status for failure to follow the Infection Control guidelines. The Immediate Jeopardy template was sent to her and she returned a signed copy on 08/20/20 at 5:13 PM. A credible allegation was accepted on 08/26/22 at 2:14 PM.

Credible Allegation of Removal of Immediate Jeopardy
Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance
All residents are at risk from the failure to adhere to correct and adequate infection control processes as guided by the Centers for Disease Control (CDC) and Centers for Medicare and Medicaid (CMS). The deficient practice occurred

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when staff were noted to be wearing masks inappropriately or not at all on the dates of 7/27/20, 7/28/20, 8/4/20, 8/5/20, and 8/14/20. Employee #1, the Director of Nursing was relieved of her duties at the Citadel of Salisbury on 7/28/20 and replaced with an Interim Director of Nursing. The Assistant Director of Nursing is no longer with the facility as of 7/31/20. The Interim Director of Nursing along with administrative staff and nursing staff to include certified nursing assistants and licensed nurses, have been re-educated on the appropriate wearing of masks, and social distancing while in the facility on 8/19/20. The Interim Director of Nursing provided re-education to Nurse #2, Social Worker #1, Social Worker #2, Receptionist #1, and Nurse #14 on the appropriate wearing of a mask in accordance with Accordius Health Policy/ Plan, the guidance from CDC and CMS. Receptionist #2 and Receptionist #3 are no longer with the facility. On 08/25/2020, the Administrator educated the employee, which was observed walking in the hallway from the loading dock without a mask, on the proper entrance to facility, where to obtain PPE upon entrance, and proper mask usage. On 08/25/2020, the cook in the dietary department and the Staff Development Coordinator was re-educated on how to properly wear a face mask, including covering the nose and mouth. Both staff members were observed with their mask under their noses. On 7/27/20 the Residents who were in the facility at the time had Point Prevalent Testing completed on 7/21/20. One resident who refused testing had been placed on 14-day Quarantine on the 300-hallway. The four residents with inconclusive results were also placed on a 14-day quarantine as per protocol. The remainder of residents, 93, resulted as

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non-detected. The most recent testing was completed on 8/21/20 including residents and staff. The resident results were 93 negatives, 3 inconclusive, and 1 positive.
Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete
Due to the fluid nature of the COVID 19 outbreak Accordius Health drafted a Policy/Plan which is updated as guidance and recommendations change and to as the latest guidance is available to each facility. As changes are made to the COVID 19 plan, this information is then properly communicated to staff from each department.
The Accordius Health COVID 19 Update will be printed by the administrator or the receptionist and provided to all employees or contract workers upon entrance each shift/day. Reminders are posted daily by each nursing station, timeclock, and via email to managers about proper use of PPE and new information about the disease process or policy changes will be kept up to date and available to all employees or contract workers on this Daily Update. The Accordius Health COVID 19 Task Force provides updated guidance, in line with CDC and CMS changes, as they occur. This information is disseminated to the Administrator and Director of Nursing, then changes are communicated to the facility staff, including agency and contracted staff.
The Nursing Home Administrator and/ or Director of Nursing re-educated all staff, from all departments, on the COVID 19 Policy/Plan on 8/26/20. This plan requires wearing a surgical mask, provided by the facility, while in the facility. Anyone not re-educated on 8/26/20 will not be allowed to work until reeducation is completed.
The in-service also included proper donning and

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F 880	Continued From page 95 doffing of surgical masks, the importance of not touching the body of the mask at any time, the requirement to keep the mask clean and in place at all times, as well as methods of preserving the integrity and cleanliness of the mask. Staff have been instructed that if their mask do not stay up on their nose and cover their mouth that they should see their supervisor to obtain a new mask per CDC and CMS guidelines The facility has designated 1 entrance/exit into the building. A staff member will monitor the entrance throughout the 3 shifts. Upon entrance to the facility, the staff member will instruct the employee on proper use of wearing the mask at all times and to ensure they are covering their mouth and nose. As staff sign into the facility and are given a copy of any updates to the COVID 19 plan they will sign a log indicating they understand the content of the information in the plan. Should staff have any questions regarding the content, a phone number will be provided to call for immediate assistance. This log will be reconciled with the sign log by the supervisor daily to ensure all staff on duty have signed for a copy of our COVID 19 plan updates and understand the content. Regional and Corporate support staff along with administrator or supervisor on duty will observe and question staff on all three shifts daily to ensure compliance with appropriate social distancing and properly wearing masks over nose and mouth. The Staff Development Coordinator is aware along with the Director of Nursing that all new hires will receive this in-service as part of orientation including proper use of PPE, including gowns, gloves, eye protection, surgical mask and if needed N95 or KN 95. The facility alleges the removal of the immediate jeopardy on 08/26/2020.	F 880		

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F 880	Continued From page 96 The credible allegation was verified during an on-stie verification conducted on 9/1/20 through interviewing facility staff to ensure that they had been educated on wearing a mask, how to appropriately wear a mask, and social distancing. Interviews were conducted with staff from multiple departments and multiple shifts and all interviewees responded they had ben educated on wearing Personal Protective Equipment (PPE) and how to appropriately wear PPE so as to prevent the potential transmission of COVID 19. All interviewed staff responded they had access to the necessary PPE to protect themselves and the residents. Multiple observations conducted throughout the facility during the on-site validation revealed staff members and residents appropriately wearing PPE, including masks. In-service records revealed education was provided regarding the use of PPE and how to properly use the PPE. Through interviews, observation, and record review, the facility was found to have effectively put into place the provided Credible Allegation of Removal of Immediate Jeopardy to a lower level and scope of severity of E (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) as of their alleged date of 8/26/20. The facility will need to continue to review and update as needed their policy/plan, complete employee education, and ensure monitoring systems in place are effective. 2. The Blood Glucose Monitoring System user's guide stated the glucometer should be cleaned using a moist lint free cloth dampened with a mild detergent. The user's guide stated all external areas of the meter including both the front and	F 880		

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back surfaces should be wiped until visibly clean. The user guide further stated, to disinfect the meter to clean the meter surface with one of the approved disinfectant wipes and then allow the surface of the meter to remain wet at room temperature for the contact time listed on the directions of the wipes. A review of the facility's "Glucometer Use and Cleaning Policy" stated, a bleach wipe should be used to wipe the Blood Glucose Monitor System of any visible materials covering all surfaces. The policy further stated soiled gloves should be removed and clean gloves donned, then use an additional wipe to allow the Blood Glucose Monitoring System to remain moist for 3 minutes and allow to air dry and return to storage case, then remove gloves and wash hands.

During an observation of the Medication Administration for Resident #27 on 7/27/2020 at 6:35 pm revealed Nurse #5 removed the glucometer from the medication cart, used the glucometer to check Resident #27's blood sugar level and placed it back into the cart without cleaning or disinfecting the glucometer. Nurse #5 stated the glucometer was used for other residents before she checked Resident #27's blood sugar level. When Nurse #5 took the glucometer from the medication cart it was in the top draw in a cardboard box with nothing to identify it as Resident #27's personal glucometer. There were no other glucometers observed in the drawer. Nurse #5 stated she did not clean the glucometer before of after using it to check Resident #27's blood sugar.

On 7/29/2020 at 12:15 pm the Director of Nursing was interviewed and stated the facility glucometers for each resident. The Director of

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F 880	Continued From page 98 Nursing stated Nurse #5 should have used Resident #5's individual glucometer to check his blood glucose level. The Director of Nursing stated Nurse #5 had worked at the facility for one week and had orientation and was educated on the facility's policy for each resident to have a personal glucometer. During an interview with the Administrator on 7/29/2020 at 12:31 pm she stated Nurse #5 should have followed the facility's policy regarding residents having a personal glucometer designated for their use. The Administrator stated she did not know why Nurse #5 did not have a glucometer for Resident #27 or why she was using the same glucometer for other residents. An interview with the Physician on 7/30/2020 at 2:28 pm was conducted and he stated the blood glucose monitor not being cleaned was an infection control issue and needed to be corrected by the facility.	F 880		
F 925 SS=E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and review of facility policy and records, the facility failed to maintain an effective pest control program as evidenced by observations of crawling pests in 1 of 2 visitor bathrooms and in the dietary department. The facility failed to implement vendor recommendations for 7	F 925	F-Tag 925 1. Ecolab was in the facility on 7/19/20 to provide pest control services 2. Previous Ecolab recommendations have been reviewed and have been addressed by the Maintenance Director on 9/9/20.	9/22/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 09/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL SALISBURY	710 JULIAN ROAD SALISBURY, NC 28147

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F 925	Continued From page 99 months to prevent breeding, nesting and burrowing of pests. The findings included: The facility Pest Control Policy, dated 2001, documented in part, that the facility would maintain an effective pest control program to ensure the building was kept free of insects and rodents. Pest control services would be provided by (named vendor) and maintenance services would assist, when appropriate and necessary, in providing pest control services. An observation of pest activity (small dark colored pest) occurred on 7/2920 at 10:30 AM in the visitor bathroom across from the service hall for the dietary department. The pests were observed crawling on the floor. A kitchen observation occurred during the lunch meal tray line on 7/29/30 from 11:50 AM to 12:15 PM. Pest activity was noted on multiple plastic meal trays that were stored on the conveyor belt of the tray line. Pests were observed crawling on the plastic meal trays. The staff were preparing to place resident's lunch plates on these trays that had been observed with crawling pests. This observation of crawling pests was brought to staff's attention. The tray line was stopped but the pest activity was not observed at that time by staff. After an unsuccessful attempt by staff to locate the pests, the staff began to resume the tray line without sanitizing the tray line or meal trays. At the request of the surveyor, staff stopped to sanitize the tray line and plastic meal trays prior to resuming the tray line. The Dietary Manager (DM) was interviewed	F 925	3. Maintenance Director has been educated on the procedure of an effective pest control program by the administrator on 9/11/20 4. The Maintenance Director will be auditing 5 areas of the facility on a weekly basis for the next 3 months to ensure the facility pest control program is effective. A copy of recommendations will be provided to the Administrator to ensure vendor recommendations and corporate sanitation audits are completed in a 5-10 day time frame. The Administrator will present results of the audits to the Quality Assurance Performance Committee monthly for 3 months. The QAPI committee can modify this plan to ensure the facility remains in compliance.	

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F 925	Continued From page 100	F 925		

during the observation and stated that the facility had previously identified a problem with cockroaches. The DM also stated that (named vendor) conducted a service visit 7/2/20 to address the problem. The DM further stated that (named vendor) would be returning for another visit soon, but she was unsure of the date. The DM further stated that she noted cockroach activity weekly in the dietary department since 7/2/20. She stated that she monitored staff regarding implementing the cleaning schedule, but that she was out in April 2020 and "We got behind on some of the cleaning." She also stated that the Corporate Food Service Director (FSD) completed Sanitation Inspections and made her aware of the findings.

During the kitchen observation on 7/29/20 from 11:50 AM to 12:15 PM. The following concerns were noted regarding potential pest breeding/harboring/entry sites: Multiple broken floor tiles were noted along the perimeter of the wall with open areas around the tiles and approximately 2- inch hole was noted in the wall next to the power switch for dish machine.

Review of the following documents recorded concerns with potential pest breeding/harboring/entry sites with repairs/cleaning recommended to reduce potential pest breeding/harboring/entry sites:

-Health Department Sanitation Inspection:
o 12/9/19, The kitchen and door frames need to be painted, there is lots of loose, flaking and peeling paint in the kitchen

-Pest Control Vendor reports:
o 3/5/20, Exit door does not close properly, ¼

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F 925	Continued From page 101	F 925		

inch gap or greater exits, floor tiles and baseboards tiles loose/missing, floor drains in need of cleaning.
- 4/2/20, Cockroaches noted behind dish pit making their nest/burrowing in the scaled paint in the bricks, cockroaches noted harboring/feeding in the wheel casters of the plate warmer, paint peeling along wall behind dish machine, wheel casters for the plate warmer and buffet line need cleaning, floor tiles and baseboards loose/missing, floor drains in need of cleaning.
o 7/19/20, floor tiles on baseboards missing/broken, grease build up in/behind dish machine, floor drains in need of cleaning with repairs/cleaning

-Corporate Sanitation Audit:
o 5/29/20, Tiles broken in dish area; paint peeling; plate warmer needs bottom wiped out;
o 6/16/20, Missing and broken tile in dish room, schedule cleaning for drain in floor, schedule detail cleaning in dish room

An observation of the dish washing area occurred with the Maintenance Director on 7/30/20 at 11:50 AM. During the observation, the wall behind the dish machine was noted with peeling paint, a hole was noted in the wall next to the power switch for the dish machine and multiple broken floor tiles were observed.. Additionally, multiple pests, identified as cockroaches, were observed, by the Maintenance Director and surveyor, crawling on the walls, floor and equipment. The Maintenance Director stated that he was new to this role for the past 2 weeks and he assisted the prior director with projects in the dietary department. He stated that he had previously grouted the floor and baseboards, but that he did not replace the broken tiles. He also stated he had not reviewed

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F 925	Continued From page 102	F 925		

all of the (named vendor) reports or the Health Department Inspection, but that he was aware of the recommendations made by (named vendor) at the 7/19/20 visit. The Maintenance Director also stated that he was aware that (named vendor) would be returning in the next day or so for a service visit to address the cockroach activity. He further stated that he had not had opportunity to complete the repairs recommended by (named vendor) and he was not aware of which door had a ¼ inch gap that could be a potential point of entry for pests. He stated he came into the dietary department once weekly for the last 2 weeks to monitor dish machine temperatures, but he did not look to see if any repairs were needed.

The FSD was interviewed on 7/30/20 at 1:00 PM. She stated that she completed sanitation audits on her last 2 visits (May 2020 and June 2020) with some concerns noted. She stated the DM addressed some things identified during the audits, but that she was still working to resolve come concerns.

An interview with the Administrator occurred on 7/30/20 at 1:30 PM and revealed she had not reviewed the (named vendor) reports and that she had not been made aware of their recommendations to reduce pest activity. The Administrator stated that she knew about the pest activity in the dietary department and that (named vendor) was conducting service visits frequently.