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	345116	A. BUILDING _____ B. WING _____	C 02/05/2021

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CAROLINA PINES AT GREENSBORO, LLC	109 S HOLDEN RD GREENSBORO, NC 27407

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E 000	Initial Comments An unannounced COVID-19 Focused and Complaint Survey was conducted on 01/11/21 through 02/05/21. 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. Event #J51Q11	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 01/11/21 to conduct an unannounced COVID-19 Focused and Complaint Survey and exited on 01/26/21 after obtaining additional information. Additional interviews were obtained on 02/04/21 and 02/05/21. Therefore, the exit date was changed to 02/05/21. Event #J51Q11 20 of 50 complaint allegations were substantiated resulting in deficiencies.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for	F 584		3/19/21

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

Electronically Signed | 02/21/2021

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F 584	Continued From page 1 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 §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 (1) maintain flooring, an overbed table, and shower room clean. (2) failed to maintain an odor free environment. (3) failed to maintain privacy curtain hooks and tracks, toilets and water faucets in good repair This was evident in 1 of 2 resident floors. (2nd floor) Findings included: 1. a. Observation on 01/12/21 at 2:18 PM revealed a 28-ounce drinking cup, soiled disposable gloves, cherries and paper covered in dust with were noted on the floor in room #225. Observation on 01/14/21 at 3:00 PM of room #225 revealed no change.	F 584	How corrective action will be accomplished for resident(s) found to have been affected: " On 01/13/2021, Room #225 was deep cleaned, and trash was disposed properly. " On 01/13/2021, the bathroom floors of room #204 were cleaned, treated, and waxed. On 02/19/2021, the overbed table in room #204 was removed and replaced with a new one. " On 01/13/2021, the bathroom in Room #207 was deep cleaned, and trash was disposed properly. The bathroom floors of room #207 were also treated and	

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F 584	Continued From page 2	F 584		

b. Observation on 01/12/21 at 2:30 PM revealed the commode seat in bathroom #204 had heavily red/orange colored stained. Observation on 1/13/21 at 11:00 AM of room #204 revealed no change

c. Observation on 01/12/21 at 2:53 PM revealed on the bathroom floor in room #207 was a used disposable razor without a covering, and black partials of an unknown substance. The perimeter of the commode base had a rust colored stain on the flooring. Observation on 1/14/21 at 2:35 PM revealed no change in the status of the bathroom floor in room #207. Housekeeper #2 (HK) was interviewed on 1/14/21 at 2:56 PM stated she had completed housekeeping duties in the bathroom of room #207 and did not see the used razor or black partials of an unknown substance.

d. Observation on 01/12/21 at 2:45 PM revealed the bathroom floor in room #229 had an accumulation of a brown colored substance.

e. Continued environmental observations with the Administrator and the Maintenance Director (MD) were conducted on 1/14/21 starting at 2:24 PM until 3:40 PM revealed the following housekeeping and maintenance issues;

" Observation revealed in room #204 the bathroom floor had a rust colored stain at the base of the commode. The base of the overbed table that was originally silver colored in room #204 was now a rust color.

" Observation of room #208 revealed 5 hooks to hang the privacy curtains on between A and B bed were missing. The hooks which were attached to the privacy curtains became stuck and would not flow freely through the tracks, when the Administrator attempted to move the curtain. The bathroom toilet would not flush. The floor at the base of the commode had a build-up of rust colored stains.

waxed.

" On 01/13/2021, the bathroom floors of room #229 were cleaned, treated, and waxed.

" On 01/13/2021, the hooks were replaced and/or added to the privacy curtain in room #208, and it now free flows through the tracks properly. Also, on 02/19/2021, the bathroom floors of room #208 were cleaned, treated, and waxed.

" On 01/13/2012, the bathroom floors of room #215 were cleaned, treated, and waxed.

" On, 01/13/2021 the bathroom was cleaned and bathroom floors of room #212 were cleaned, treated, and waxed.

" On 01/14/2021, the bathroom faucet in room #212 was fixed to stop the leak.

" On 01/13/2012, the shower room on the 2nd floor was deep cleaned and trash was disposed of properly. The shower stretcher was also deep cleaned and sanitized. The toilet in the shower room was unclogged. The ceiling tiles were replaced. The floor grout was cleaned and treated.

" On 01/15/2021, the bathroom was deep cleaned and bathroom floors of room #231 were cleaned, treated, and waxed.

How corrective action will be accomplished for resident(s) having potential to affected by the same issue needing to be addressed:¿

" On 02/19/2021, Housekeeping Manger will in-service housekeeping staff on proper policies and procedures for resident/patient room cleaning, restroom cleaning, deep cleaning, privacy curtain

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F 584	Continued From page 3 " Observation revealed the bathroom floor in room #215 had rust colored stains around the perimeter of the base of the commode and the sink in the bathroom also had a rust covered stain. " Observation revealed in bathroom #212 was an offensive lingering odor. The floor around the base of the commode was stained. There was a build-up of a brown colored substance in the corners of the bathroom floor. The faucet in the bathroom continued to leak when attempts were made to turn the water off. " Observation of the 2nd floor shower room revealed a hairnet with strands of hair and soiled gloves were lying on the floor. Strands of hair were also noted on the stretcher used for showers. The toilet in the shower room was stopped up. Three (3) ceiling tiles had brown colored stains. The floor grout in the shower room was dark colored in multiple areas. " Observation of bathroom #231 revealed a strong lingering offensive odor. An accumulation of stains on the floor tiles. Interview on 1/14/21 at 3:30 PM with HK #1 stated "I must have just missed the items left on the floor" in room #225. Interview on 1/13/21 at 1:13 PM with the HK manager (from the housekeeping contract services) stated he recently transferred to this facility to address cleaning problems and staff are cleaning the rooms. Telephone interview with the Administrator on 1/21/21 at 10:28 AM stated HK services are a contracted service and that there had been a lot of staff changes over the last few months. She stated the company has been recruiting new staff and believed they are almost fully staffed. She discussed the environmental manager overseeing the HK staff and ensuring they	F 584	cleaning/placement, and floor cleaning (based on job responsibilities). In-services will be completed by 03/19/2021. What measure will be put in place or systemic changes made to ensure that the identified issue does not occur in the future: " Housekeeping Manger staff will be educated upon hire and annually, on proper policies and procedures for resident/patient room cleaning, restroom cleaning, deep cleaning, privacy curtain cleaning/placement, and floor cleaning (based on job responsibilities). Indicate how the facility plan to monitor its performance to make sure that solutions are achieved and sustained: " Housekeeper Manger will randomly select 3 resident rooms/common use rooms and audit them using the environmental audit tool 5 x per week, weekly times 1 month, and monthly times 3 months. Housekeeper Manger will report audit findings monthly to the QAPI team for review times 3 months.¿ Documentation of the review will be kept by the Administrator in the QAPI Book.¿ " Ongoing random audits will also be conducted by Housekeeping Manger and negative findings will have corrective actions and presented at the next QAPI meeting.	

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F 584	Continued From page 4 complete their jobs but that the facility's leadership team also makes rounds daily to identify any issues. She stated she expected the HK department to maintain the floors in a clean condition.	F 584		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.	F 660		3/19/21

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(vi) Address the resident's goals of care and treatment preferences.
(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.
(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.
(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.
(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.
(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.
(ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the

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F 660	Continued From page 6 discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on record review, family, staff, nurse practitioner and home health agency interviews, the facility failed to implement an effective discharge plan for a resident who required home health services, foot care, physical therapy and occupational therapy when discharged from the facility for 1 of 3 residents (Resident #12) who were discharged from the facility to home. The findings included: Resident #12 was admitted to the facility on 04/17/20 with diagnoses of acute post hemorrhagic anemia, neurogenic bowel, neuromuscular dysfunction of bladder, severe protein- calorie malnutrition, migraines, major depressive disorder, moderate quadriplegia, abnormal postures, need for assistance with personal care, other muscle spasm, neuralgia and non-pressure chronic ulcer of right calf. A review of the quarterly Minimum Data Set (MDS) dated 08/13/20 revealed Resident #12 was cognitively intact. Resident #12 was able to communicate his needs to staff. He required extensive assistance to total dependence on staff for all his activities of daily living (ADL's). Resident #12 was always incontinent of urinary and bowel. A review of Resident #12's care plan dated 05/25/20 indicated Resident # 12 was completely dependent on staff for all his activities of living daily. Resident #12 was also care planned for	F 660	How corrective action will be accomplished for resident(s) found to have been affected: • On 08/24/2021 resident # 12 was discharged home with no home health services setup. • The SW completed an audit for the discharges for the month of January 2021 to ensure the discharge planning process was implemented per facility protocol to verify that all residents discharged received home health services identified in the facility as ordered by the medical provider • On 02/15/2021 Administrator educated social services director on discharge planning and discharge process policies/procedures. How corrective action will be accomplished for resident(s) having potential to affected by the same issue needing to be addressed:¿ • On 02/15/2021 Administrator educated social services director on discharge planning and discharge process policies/procedures. • The Social Worker Director will contact home health agency pre and post discharge to ensure services are implemented in the community. What measure will be put in place or systemic changes made to ensure that the identified issue does not occur in the future:	

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F 660	Continued From page 7 being resistant to care and resistive of taking medication related to adjustment to nursing home placement. Resident #12's care plan contained a discharge plan that indicated he would be discharged into an apartment with home health services. A review of the physician's progress note dated 08/13/20 indicated Resident #12 had an anticipated discharge date to home of 08/21/20. The physician noted in the progress note the resident had a right leg pressure ulcer that had improved. A review of the facility's Post-Discharge Plan of Care dated 08/18/20 indicated Resident #12 would have community resources and service planning. Nursing needs were identified for disease and medication management, personal care, home health aide, registered nurse, mechanical lift, hospital bed with pressure relieving mattress, shower chair, physical and occupational therapy. The discharge plan of care indicated Home Health Agency #1was notified and the referral had been completed and signed by the Facility Social Worker. A review of the discharge summary history from the Facility Nurse Practitioner (NP) dated 08/19/20 indicated Resident #12 was seen on 08/19/20 and he denied any acute concerns. The NP noted, "Discussed discharged instructions. Verbalized understanding. Plan: Medically cleared for discharge to home this week with home health, physical and occupational therapy evaluations and treatment for endurance training and to prevent muscle wasting. Home health nurse for medication, disease management and wound care, Home health aide for assistance with	F 660	• The administrator will complete an audit of discharges in the last 30 days to ensure that the discharge was safe, and that all paperwork was completed properly by Social Services Director. • Any residents who were missing discharge orders for outside services are made aware to Social Services Director. • IDT will review discharge orders daily. • Social Worker Director will audit patients discharge orders weekly. Indicate how the facility plan to monitor its performance to make sure that solutions are achieved and sustained: • Social Service Director will review discharges 5 x per week, weekly times 1 month, and monthly times 3 months to ensure that the discharge without side services are completed and is completed properly by Social Services Director. The administrator will report audit findings monthly to the QAPI team for review times 3 months.¿ Documentation of the review will be kept by the Administrator in the QAPI Book. • Ongoing random audits will also be conducted by Social Worker Director and negative findings will have corrective actions and presented at the next QAPI meeting.	

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activities of daily livings. Semi-electric hospital bed with pressure relieving mattress/gel overlay which is required to patient's complete immobility secondary to quadriplegia. Patient also has pressure ulcer to posterior right lower leg. Hoyer lift for transfers. Patient requires maximum assistance for all transfers due to complete immobility secondary to quadriplegia. Standard bath chair with back support for toileting needs. Patient needs all the durable medical equipment possibly all his life due to complete immobility secondary to quadriplegia. Follow-up with primary care physician in 2 weeks after discharge. Medication reviewed and scripts signed."

A review of the physical therapy discharge summary on 08/20/20 revealed Resident #12 planned to discharge home on 8/21/20 and would have a new electric wheelchair and mechanical lift at home. Home health physical therapy was recommended to ensure a safe transition to home environment.

A review of the occupational therapy discharge summary dated 08/20/20 for Resident #12 indicated discharge recommendations included assistance with ADL's, an air mattress, low bed, mechanical lift and home health services.

A review of the Interdisciplinary Discharge Summary dated 08/24/20 for Resident #12 identified he was discharged home on 8/21/20 and would have home health services, physical and occupational therapy and other equipment needed for his placement home. The facility Social Worker signed this summary on 8/20/20.

A nursing progress note dated 08/24/20 indicated Resident #12 was discharged on 8/24/20 rather

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than the earlier planned date of 8/21/20. This progress note was written by Nurse #21.

Attempts to interview Nurse #21 during the survey were unsuccessful.

An interview was conducted with the Physical Therapist (PT) on 01/14/21 at 11:00 am, who indicated Resident #12 needed maximum assistance with all his ADL's and Resident #12 needed to have physical therapy in place at discharge. The PT revealed it would be the facility's responsibility to set up physical therapy services before Resident #12 was discharged. The PT indicated the Social Worker would be the person to discuss this with however physical therapy services were a part of Resident #12's discharge plan.

An interview was conducted with the Occupational Therapist (OT) on 01/14/21 at 11:30 am, who indicated Resident #12 needed maximum assistance with his occupational goals, he needed hand rolls to protect his thumb from increased contracture to prevent increased risk of infections. The OT stated Resident#12 needed engagement to continue body movement for improved strength and range of motion, a mechanical lift and 24-hour care. The OT also indicated it was the facility's responsibility to set this service up for Resident #12 before he was discharged.

During an interview with a family member on 01/12/21 at 12:30 pm they indicated Resident #12 was discharged home on 08/24/20 and was supposed to have home health services including physical and occupational therapy. The family member revealed the facility had told her the

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home health agency would contact her within 48 hours of discharge, but she never heard from anyone. The family member stated the resident also had issues with foot care that were unrelated to the pressure sore that he had while residing at the facility. The Family member stated she got what she needed from the facility to care for his posterior leg pressure sore. but was unprepared to care for wounds on his toes she found when he arrived home. The Family Member (FM) for Resident #12, FM added on 08/24/2020 she removed the resident's socks and both of his big toes were black and blue in color. The FM explained the resident's toenails had grown so long, they were split and looked infected. The FM stated she called the facility and the resident's doctor about the condition of his feet. The FM indicated she provided pictures to the facility and the facility according to the FM called and got medication and supplies to treat the resident's feet. She explained the staff from the facility came to her home on 8/25/20 with a treatment that had been ordered by the facility Nurse Practitioner (NP). They provided bacitracin ointment and an anti-fungal cream to be applied twice daily for 7 days. The FM stated Resident #12's primary doctor had a skype visit on 8/25/20 and arranged for the resident to see a podiatrist for his feet. The family member confirmed that the resident had the medical equipment that he needed when her arrived home, but the issue was the lack of home health agency care. The family member revealed the resident did not receive home health services for 4 to 6 weeks after discharge from the facility.

The FM also indicated that on 08/27/20 no one from the Home Health Agency had reached out to Resident #12 so she contacted the facility FSW

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and reported this information to her.

During a second interview with Resident #12's family member on 01/19/21 at 12:45 pm she stated the resident waited a month at home before receiving home health services, physical and occupational therapy services. The family added it was a state social worker that helped her finally get these services set-up.

During a third interview on 02/04/21 at 12:30 pm Resident #12's family member she revealed the resident's primacy doctor provided an antibiotic for 4 days to treat his toe after his discharge from the facility and recommended that Resident #12 be seen by a podiatrist as soon as possible. The FM also indicated staff from the facility did not educate her on the care needs for Resident #12's foot care and they just assumed she knew because she was a nurse. The FM confirmed that it took until 09/01/20 for Home Health Services to begin for Resident #12. The FM stated during the time it took for home health services to start Resident #12 was not able to get out of bed because he needed two-person assistant with the Hoyer lift and the FM was not able to do this by herself. The FM indicated she ended up moving from out of state into Resident #12's apartment to help with his care. During this interview FM indicated that she provided all of Resident #12's activities of daily living on the day he was discharged until 09/01/20 by herself. However, on 09/01/20 the Home Health Agency begin with the help of agency nurses and agency certified nursing assistants to help with Resident #12's activities of daily living care and treatment.

An interview was completed with the former Social Worker (SW) on 01/14/21 at 1:30 pm. She

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indicated she completed all the discharge paperwork for Resident #12. The SW indicated she set up home health services with an agency before Resident #12 was discharged home, but indicated she was unsure of what home health agency she had contacted because she was no longer employed at the facility. She stated she left all the paperwork in the office and the discharge information was in her notes. The SW explained Resident # 12 had been discharged on 8/24/20 and Resident #12's family called on 08/25/20, requesting help with the resident's foot care. She added she gave a picture of Resident #12's foot concerns to the DON and Administrator, the day after Resident #12 was discharged home with family. During this interview with the FSW she indicated that Resident #12's family member called her on 08/27/20 and reported that no one from the Home Health Agency had reach out to Resident #12.

On 01/14/21 at 2:00 pm a phone interview was conducted with a receptionist who worked for Home Health Agency #1. This was the home health agency that was specified on Resident #12's discharge summary dated 08/24/20. The receptionist stated there was no record of a referral to their agency for Resident #12. The receptionist indicated she looked back to August 2020 and found no information that the facility had faxed any referral information for Resident #12 and found no information that this agency provided any services or treatments for the resident.

On 1/14/21, the facility provided a faxed document which the Social Worker faxed to Home Health Agency # 2. The fax was dated 08/27/20 and included all the information needed

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for a safe and orderly discharge for Resident #12.

A phone call was made on 01/14/21 at 2:15 pm to the Home Health Agency # 2. This was the home health agency listed on the fax dated 08/27/20 after Resident #12 was discharged home. The Agency Receptionist indicated they had not received any information from the facility for Resident #12 for home health services with this agency. The Receptionist also indicated Resident #12's name was not in their data base for the entire year of 2020 and they had not received any referral from the facility for this resident.

During an interview with the Director of Nursing on 01/12/21 at 3:30pm, she indicated the Social Worker would have handled Resident #12's discharge.

An interview was conducted with the Nurse Practitioner (NP) on 01/14/21 at 3:45 pm and revealed she completed a discharge summary for Resident #12 on 08/19/20 and all Resident #12's discharged instructions were given to the facility to give to the family. The NP indicated she signed all of Resident #12's medications for home and assessed Resident #12 on that day as well. The NP indicated a medication list was attached to her summary for Resident #12. The NP indicated no knowledge of Resident #12 having any foot care issues and/or a pressure ulcer on his toes. She stated she was under the impression that the facility had followed the instruction for his discharge and had set up all the services Resident #12 needed before his was discharged home. The NP added Resident #12 required maximum assistance with all his ADL's and needed a mechanical lift to help with transfers.

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F 660	Continued From page 14 During an interview with Director of Nursing on 01/14/21 at 4:00 pm, she stated she was unsure what home health agency the SW had put in place for Resident #12. She stated that Resident #12's family member called the facility the day after he was discharged and indicated concerns with Resident #12's foot care and the facility provided supplies to address those concerns. According to the DON, the resident had issues with his feet upon facility admission but refused to allow staff to touch or care for his feet while he resided at the facility, and therefore facility staff were not aware of any issues with the resident's feet prior to discharge. During an interview with the Administrator on 01/25/21 at 10:05 am, the Administrator indicated that the former Social Worker was responsible for completing the discharged for Resident #12. The Administrator indicated that the SW knew that the only way Resident #12 could be discharged was for Home Health Services to be in place because Resident #12 was totally dependent on staff and required maximum assistance with all his activities of daily living.	F 660		
F 677 SS=D	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 observation, staff interview and record review the facility failed to provide incontinence care to keep residents clean for 1 of 3 sampled residents who were dependent on staff for	F 677	How corrective action will be accomplished for resident(s) found to have been affected: " On Resident #11 was provided	3/19/21

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F 677	Continued From page 15 activities of daily living (Resident #11). Findings included: Resident #11 was admitted to the facility on 01-15-2016 with multiple diagnoses which included congestive heart failure, hypertension, paraplegia, and Parkinson ' s disease. The Minimum Data Set (MDS) dated 12-07-2020 revealed that Resident #11 was cognitively intact. Resident #11 was coded as needing extensive assistance with 2 people assist for bed mobility, total dependence with 1 person assist for transfers, total dependence with 2 people assist with toileting and personal hygiene. A review of the care plan dated 12-06-2020 revealed that Resident #11 needed assistance with activities of daily living (ADL). Interventions included to provide assistance with personal hygiene and total care with toilet use. An observation of staff providing Resident #11 with incontinent care was conducted on 01-12-2021 at 1:52 pm. The care was performed by nursing assistant (NA) #6 and Nurse #1. NA #6 was observed to remove the resident ' s urine soiled brief and applied a clean brief without washing Resident #11 perineal area. NA #6 was interviewed on 01-12-2021 at 1:54 pm. She confirmed she did not clean Resident #11 when she provided the observed incontinent care. NA #6 stated Resident #11 wets a lot and she would clean her when the resident was overly wet. Nurse #1 was interviewed on 01-12-2021 at 1:56	F 677	incontinence care. " On 01/13/2021, DON in-serviced NA #6 and Nurse #1 on proper incontinence care policy and procedures. How corrective action will be accomplished for resident(s) having potential to affected by the same issue needing to be addressed: " On 02/19/2021, DON will in-service clinical staff (Nurses and Aides) on proper incontinence care policy and procedures. In-services will be completed by 03/19/2021. What measure will be put in place or systemic changes made to ensure that the identified issue does not occur in the future: " Clinical staff (Nurses and aides) will be educated upon hire, on proper incontinence care policy and procedures. Indicate how the facility plan to monitor its performance to make sure that solutions are achieved and sustained: " DON will randomly select 1 certified nursing assistant and observe them perform incontinence care 5 x per week, weekly times 1 month, and monthly times 3 months. DON and/or designee will report audit findings monthly to the QAPI team for review times 3 months. Documentation of the review will be kept by the Administrator in the QAPI Book. " Ongoing random audits will also be conducted by Administrator and/or nurse management, and negative findings will have corrective actions and presented at the next QAPI meeting.	

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F 677	Continued From page 16 pm. He stated the facility does not use wipes so the resident would have to have a bed bath when she was incontinent. An interview with the Director of Nursing (DON) occurred on 01-13-2021 at 12:11 pm. The DON stated she was not sure why the NA did not provide incontinent care. She stated the staff knew they were to provide incontinent care, which included washing the resident ' s perineal area, after each incontinent episode.	F 677		
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on record review, family, staff, physician, nurse practitioner and podiatry representative interviews the facility failed to identify and treat a resident's long toenails for 1 of 3 sampled residents reviewed for foot care (Resident #12). Resident #12 experienced a right 1st ingrown toenail on both borders of the nail with drainage and the resident complained of pain related to the ingrown nail. Resident #1 had his right 1st toe nail excised by a podiatrist.	F 687	How corrective action will be accomplished for resident(s) found to have been affected: " Facility provided Resident #12□s family with supplies to care for his feet the day after he was discharged. How corrective action will be accomplished for resident(s) having potential to affected by the same issue needing to be addressed:	3/19/21

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F 687	Continued From page 17 The findings included. Resident #12 was admitted to the facility on 04/17/20 with diagnoses of acute post hemorrhagic anemia, neurogenic bowel, neuromuscular dysfunction of bladder, severe protein- calorie malnutrition, migraine, major depressive disorder, moderate quadriplegia, neuralgia, and non-pressure chronic ulcer of right calf. A review of Resident #12's care plan dated 05/25/20, identified Resident # 12 was totally dependent on staff for all his activities of living daily. Resident #12 was care planned for being resistive to care including refuses suppository, ADL care, incontinent care and medications related to adjustment to nursing home. Review of the care plan revealed no plan of care related to foot care. A review of the quarterly Minimum Data Set (MDS) dated 08/13/20 revealed Resident #12 was cognitively intact. Resident #12 was able to communicate his needs to staff. He required extensive to total dependence on staff for all his activities of daily living (ADLs). A review of a physician's (MD) progress note dated 08/13/20 indicated Resident #12 was seen today and he stated his bilateral leg and back pain was better controlled with current analgesia. The right leg pressure ulcer was much improved with no signs of infection currently. Post completion of antibiotic. Wound care specialist to continue to follow-up with patient. Anticipated discharge to home next Friday. No other complaints or concerns reported by the nursing	F 687	" Beginning 02/19/2021 DON and Administrator will in-service clinical staff (Nurses and Aides) on proper way to conduct skin assessments and complete competency check off. In-services and education will be completed by 03/19/2021. What measure will be put in place or systemic changes made to ensure that the identified issue does not occur in the future: " On 02/19/2021 DON and Administrator began audit of current residents to ensure they have received a skin weekly assessment. Audit will be completed on 03/19/2021. " A skin assessment was completed for residents who did not have a current skin assessment in place, and findings/review was documented in their chart. " Residents who required treatment for skin issues/pressure wounds were followed up with by DON, treatment nurse, and/or designee and referred to appropriate providers, as necessary (Physician, Podiatrist, etc).	

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staff. There was no information regarding the resident's feet.

During an interview with the MD on 01/14/21 at 4:30 pm, he indicated that he did not recall any issues with Resident #12's discharge and indicated the Nurse Practitioner (NP) handled Resident #12's discharge.

A review of the discharge summary from the Facility Nurse Practitioner dated 08/19/20 indicated Resident #12 was seen and he denied any acute concerns. He stated his pain was more controlled with current analgesia. No other complaints or concerns reported by the nursing staff. Discussed discharge instructions. Verbalized understanding. Plan: Medically cleared for discharge to home this week with home health, physical and occupational therapy evaluations and treatment for endurance training and to prevent muscle wasting. Home health nurse for medication, disease management and wound care, Home health aide for assistance with activities of daily livings. Semi-electric hospital bed with pressure relieving mattress/gel overlay which is required to patient's complete immobility secondary to quadriplegia. Patient also has pressure ulcer to posterior right lower leg. Mechanical lift for transfers. Patient requires maximum assistance for all transfers due to complete immobility secondary to quadriplegia. Standard bath chair with back support for toileting needs. Patient needs all the durable medical equipment possibly all his life due to complete immobility secondary to quadriplegia. Follow-up with primary care physician in 2 weeks after discharge. Medication reviewed and scripts signed. There was no information in the note related to the resident's feet.

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An interview was conducted with the Nurse Practitioner (NP) on 01/14/21 at 3:45 pm and revealed she completed a discharge summary for Resident #12 on 08/19/20 and all Resident #12's discharged instructions were given to the facility to give to the family. The NP indicated she signed all of Resident #12's medications for home and assessed Resident #12 on that day as well. The NP indicated a medication list was attached to her summary for Resident #12. The NP indicated no knowledge of Resident #12 having any foot care issues and/or a pressure ulcer on his toes. She stated she was under the impression that the facility had followed the instruction for his discharge and had set up all the services Resident #12 needed before his was discharged home. The NP added Resident #12 required maximum assistance with all his ADL's and needed a mechanical lift to help with transfers. During this interview the FNP also indicated that she had spoke with the DON on 08/25/20 concerning an issue with Resident #12's feet once he got home and she indicated treatment was given to DON for Resident #12 on that day. FNP indicated that she never assessed Resident #12's feet during his stay at the facility.

A review of Resident #12's skin assessments from 04/17/20 to 08/21/20 did not identify any concerns regarding the skin on the resident's feet.

Review of Resident #12's medical record revealed there were no documentation of podiatry services being provided during the resident's stay at the facility.

A nursing progress note dated 08/24/20, written

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by Nurse #21, indicated Resident #12 was discharged on 8/24/20 rather than the earlier planned date of 8/21/20. This progress note did not contain any information or concerns about the resident's feet.

Attempts to interview Nurse #21 during the survey were unsuccessful.

Attempts were also made, during the survey, to contact several nursing assistants and nurses who cared for Resident #12, during his stay at the facility, but these attempts were unsuccessful.

During a telephone interview with a family member (FM) of Resident #12 on 01/12/21 at 1:30 pm, the FM stated the resident was discharged from the facility to home on 08/24/2020. She added on 08/25/2020 she removed the resident's socks and both of his big toes were black and blue in color. The FM explained the resident's toenails had grown so long, they were split and looked infected. The FM stated she called the facility and the resident's doctor about the condition of his feet. The FM indicated she provided pictures to the facility and the facility called to obtain medication and supplies to treat the resident's feet. She explained the staff from the facility came to her home on 8/25/20 with a treatment that had been ordered by the facility Nurse Practitioner (NP). They provided bacitracin ointment and an anti-fungal cream to be applied twice daily for 7 days. The FM stated Resident #12's primary doctor had a skype visit on 8/25/20 and arranged for the resident to see a podiatrist.

During another telephone interview with Resident #12's FM on 02/04/21 at 12:30 pm she revealed

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the resident's primacy doctor provided an antibiotic for 4 days to treat his toe after his discharge from the facility and recommended that Resident #12 be seen by a podiatrist as soon as possible. The FM also indicated staff from the facility did not educate her on the care needs for Resident #12's feet and they just assumed she knew because she was a nurse. The FM confirmed that it took until 09/01/20 for Home Health Services to begin for Resident #12. The FM stated during the time it took for home health services to start Resident #12 was not able to get out of bed because he needed two-person assistant with the Hoyer lift and the FM was not able to do this by herself. The FM indicated she moved into Resident #12's apartment to help with his care. During this interview FM stated that she provided all of Resident #12's activities of daily living on the day he was discharged from the facility on 08/24/21 until 09/01/20 by herself. However, on 09/01/20 the Home Health Agency services began, and the agency's nurses and nursing assistants helped her with Resident #12's activities of daily living care and treatments.

On 02/05/21 at 1:32 pm Resident #12's family member provided the written statement that she informed the facility on 08/24/20 after Resident #12's discharge from the facility. The FM's 08/24/20 the information to the facility read in part, after Resident #12 was discharged, "When undressing Resident #12 noted a blood and brown liquid spot on his white sock on the right foot. Sock was stuck to his foot and on removal noted right great toe to be black with large amount of thick yellow brown drainage along with bloody drainage. Noted all toenails on both feet to be approximately 1 to 1 ½ inches long and inverted into the nail beds. Two black areas noted

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on the outside of both left and right feet and small amount of bleeding to right great toe."

An interview was conducted on 1/14/21 at 3:00 pm with the facility's former Social Worker (SW), who worked at the facility when Resident #12 was discharged on 08/24/20. The SW indicated Resident #12's family called her about the condition of resident's feet on 08/25/20 and emailed her pictures of Resident #12's feet. The SW stated she reported this information to the Director of Nursing (DON) and Administrator along with the pictures. During this interview the SW revealed nothing about Resident #12 having any concerns with the care of his feet or seeing a podiatrist during his stay at the facility.

During an interview with DON on 01/14/21 at 4:00 pm, she stated Resident #12's family member called the facility the day after he was discharged (08/25/20) and voiced concerns about his feet and the facility provided supplies to address those concerns. The DON explained she spoke with the NP who was in the facility that day and the NP gave an order for bacitracin ointment and an anti-fungal cream twice daily for 7 days. The DON stated Resident #12's family told her "you couldn't see the sore on his foot because it was underneath all that crust and she had used peroxide to clean the toe up and once all the black stuff was gone the wound was there". The DON added she encouraged Resident #12's family member not to use hydrogen peroxide due to contraindications.

Review of a podiatry visit note dated 9/24/20 for Resident #12 revealed the resident had a right 1st ingrown nail on both borders with drainage and dark lesions on the sub 5th digits bilaterally

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both with duration unknown. The resident complained of pain related to the ingrown nail. The right 1st nail was excised during this visit.

During an interview with a staff member at the Podiatrist office on 01/24/21 at 2:00 pm they revealed Resident #12 was a patient at this office on 09/24/20 and review of Resident #12's chart revealed he had two wounds on his feet. Resident #12 had a right 1st ingrown nail on both borders with drainage and dark lesions on the sub 5th digits bilaterally both with duration unknown.

Multiple attempts including phone calls and submission of a letter from the state agency requesting an interview with the Podiatrist who treated Resident #12 on 09/24/20 were made, but the Podiatrist did not provide a response.

During a second interview with the DON on 01/25/21 at 9:43 am, she revealed Resident #12's feet were horrible on admission and he would not let staff care for his feet. She reiterated that the facility had provided Resident #12's family with supplies to care for his feet the day after he was discharged.

During an interview with the Administrator on 01/25/21 at 10:05 am, the Administrator indicated Resident #12 had no issues with his feet during his stay at the facility. She stated she was informed by the former Social Worker that the resident's family had called about Resident #12's foot care. The Administrator added the DON contacted the family and provided what was needed for his foot care. She explained Resident #12 required maximum assistance with all his ADLs when he was at the facility. Administrator indicated nothing about Resident #12 needed foot

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F 687	Continued From page 24 care during his stay at the facility. Administrator just stated that according to staff Resident #12 was resistant to some of his care and treatment at the facility. No podiatry services were provided to Resident #12 during his stay at this facility.	F 687		
F 690 SS=D	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	F 690		3/19/21

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F 690	Continued From page 25 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: Based on record review, observations, resident interview and staff interviews the facility failed to keep the indwelling urinary catheter stabilized and the urinary drainage bag and tubing from looping, touching and dragging on the floor. This was evident in 1 of 3 residents reviewed for urinary catheters (Resident #1). The findings included: Resident #1 was admitted to the facility on 8/13/20 with cumulative diagnoses which included diabetes, atrial fibrillation and an indwelling urinary catheter (a catheter into the bladder to drain urine) due to an obstructive uropathy. Obstructive uropathy is a condition where urine flow has been partially or completely blocked. Review of the significant change Minimum Data Set (MDS) assessment dated 12/11/20 coded a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact. The MDS also coded Resident #1 as requiring extensive assistance from staff for toilet use and had a urinary appliance. There were with no behavioral issues coded. Review of the written care plan with a target date of 11/25/2020, indicated in part a goal for Resident#1 to remain free from catheter related trauma through the next review. There were no approaches written to keep drainage bag and tubing off the floor, stabilize the catheter or an	F 690	How corrective action will be accomplished for resident(s) found to have been affected: " On 01/13/2021, PR removed Resident #1□s urinary drainage bag and tubing from looping, touching, and dragging on the floor. A stabilization device was also assigned to reduce tension on the tubing and facilitate urine flow. " On 01/13/2021, PR removed Resident #4□s urinary drainage bag and tubing from looping, touching, and dragging on the floor.¿¿A stabilization device was also assigned to reduce tension on the tubing and facilitate urine flow. How corrective action will be accomplished for resident(s) having potential to affected by the same issue needing to be addressed:¿ " On 01/13/2019, current residents with urinary catheters were reviewed by the DON for catheter care to ensure their catheter bags were not in contact with the floor.¿ If there was any deficiency, the MDS Nurse corrected immediately.¿ " On 01/13/2021, DON started re-education to current licensed nurses and nursing assistants regarding the facility policy on bowel/bladder incontinence, catheter care, and UTIs. Education will be completed on 03/19/2021. What measure will be put in place or	

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F 690	Continued From page 26 approach to keep the urine from stagnating in the middle of the loop of the tubing. Observation on 01/11/21 at 11:00 AM revealed the urinary catheter drainage tube was positioned directly on the floor while Resident #4 was sitting in a wheelchair in her room. There was no stabilizer to the urinary catheter. When the resident moved from her room to the physical therapy room the urinary tubing dragged on the floor. Observation on 01/11/21 at 2:00 PM revealed Resident #1's urinary catheter drainage bag was touching the floor and the drainage tube was positioned on the floor and looped in the manner to cause the urine to stagnate in the middle of the loop. Observation on 01/12/21 at 2:18 PM revealed Resident #1's urinary catheter drainage tube continued to be positioned on the floor and looped in the manner to cause the urine to stagnate in the middle of the loop. Record review of the Medication Administration Record (MAR) with a start date 01/13/21 indicated "use catheter securing device to reduce excessive tension on the tubing and facilitate urine flow. Rotate site of securement daily and prn [whenever necessary]." Observation on 1/13/21 at 12:39 PM revealed the resident's urinary catheter had no stabilization device and the urinary drainage bag was touching the floor while the resident was lying in bed. Interview during this observation with Resident #1 stated her catheter and tubing was always placed on her left leg without any device attached so the	F 690	systemic changes made to ensure that the identified issue does not occur in the future: " On 02/19/2021, The DON will complete a weekly Catheter Bag audit to ensure residents with urinary catheters had their catheter bags positioned so they were not in contact with the floor and that they were using a stabilizing device. Indicate how the facility plan to monitor its performance to make sure that solutions are achieved and sustained: " The DON will review catheter audit tools 5 x per week, weekly times 1 month, and monthly times 3 months,¿catheter audit reported findings monthly to the QAPI team for review times 3 months.¿ Documentation of the review will be kept by the Administrator in the QAPI Book.¿ " Ongoing random audits will also be conducted by the DON, and negative findings will have corrective actions and presented at the next QAPI meeting.	

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catheter would not move.

Interview on 1/13/21 at 12:51 PM with Nursing Assistant (NA) #7 stated catheter care was the responsible of both the nurse and the nursing assistant. The tubing should be positioned so that the urine flows by gravity. The tubing and drainage bag should not touch the floor. NA #7 also stated that the facility used leg straps to stabilize urinary catheters.

Interview on 1/13/21 at 12:58 with Nurse #2 stated the NA should notify the nurse when there is a concern about the stabilization or positioning of a resident's urinary catheter.

Interview on 1/13/21 at 1:00 PM with NA #6 (assigned to care for the resident) stated she had not seen a method to stabilizer Resident #1 urinary catheter but would get something. NA #6 stated she had not informed anyone about not having a stabilizer for Resident #1's urinary catheter and was unaware of the resident's drainage tubing and drainage bag not properly positioned.

Interview on 1/13/21 at 1:10 PM with Nurse #1 (charge nurse) stated the NA never told him that Resident #1 needed a stabilizer for her urinary catheter.

Interview on 1/13/21 at 3:30 PM with the Certified Medication Aide (CMA)/central supply staff #3 stated the nurse and the NA are responsible for making sure the urinary catheter was stabilized and kept off the floor. CMA/central supply staff #3 stated the facility had an anchoring device to stabilize the urinary catheter in stock.

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F 690	Continued From page 28 Interview 1/13/20 at 3:45 PM with the Director of Nurses stated the urinary drainage bag or tubing should not touch the floor, the position the tubing should be positioned so urine would be free flowing, and the catheter should be stabilized.	F 690		
F 755 SS=D	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 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	F 755		3/19/21

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F 755	Continued From page 29 is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review, consultant pharmacist, and staff interviews, the facility failed to have a system in place for reconciling controlled medication by accounting for Norco 5-325 milligrams (mg) for Resident #24 for 1 of 3 residents reviewed for the use of a controlled substance. The findings included: 1.Resident #24 was admitted to the facility on 08/13/2019. A review of Resident #24's Medication Administration Record (MAR) revealed a physician's order to start on 5/29/2020 Norco (Hydrocodone-Acetaminophen) 5-325 milligrams (mg) (an opioid and non-opioid combination medication) to be given one tablet by mouth every 6 hours as needed for pain. Norco is a controlled medication. Resident #24 "Medication Monitoring/Control Record" (a controlled substance declining inventory sheet) indicated 9 doses of Norco 5 mg were pulled from the medication cart from 10/06/2020 to 12/08/2020 on the following dates: a. On 10/06/20 at 10:30 PM, 1 dose of Norco was documented as removed from the med cart; b. On 10/08/20 at 11:00 AM, 1 dose of Norco was documented as removed from the med cart; c. On 10/12/20 at 10:40 PM, 1 dose of Norco was documented as removed from the med cart; d. On 10/20/20 at 9:30 PM, 1 dose of Norco was documented as removed from the med cart; e. On 11/07/20 at (time unclear? if 2:57 AM), 1 dose of Norco was documented as removed from the med cart; f. On 11/14/20 at 3:37 AM, 1 dose of Norco was	F 755	How corrective action will be accomplished for resident(s) found to have been affected: " On 01/13/2021 DON educated staff nurses on the process for the administration of controlled substances process policies/procedures. How corrective action will be accomplished for resident(s) having potential to affected by the same issue needing to be addressed: " On 01/13/2021 DON educated staff nurses on the process for the administration of controlled substances process policies/procedures. Will be completed 03/19/2021 What measure will be put in place or systemic changes made to ensure that the identified issue does not occur in the future: " The DON will complete an audit PRN mediation admiration records in dealing with narcotics in PCC against narcotic sheets for accuracy. Indicate how the facility plan to monitor its performance to make sure that solutions are achieved and sustained: " DON will review any 5 x per week, weekly times 1 month, and monthly times 3 months to ensure for accuracy. DON will report audit findings monthly to the QAPI team for review times 3 months. Documentation of the review will be kept by the Administrator in the QAPI Book. " Ongoing random audits will also be conducted by Administrator and/or nurse	

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F 755	Continued From page 30 documented as removed from the med cart; g. On 11/29/20 at 5:42 PM, 1 dose of Norco was documented as removed from the med cart; h. On 12/04/20 at 6:20 PM, 1 dose of Norco was documented as removed from the med cart; i. On 12/06/20 at 10:35 AM; 1 dose of Norco was documented as removed from the med cart; j. On 12/08/20 at 9:27 AM, 1 dose of Norco was documented as removed from the med cart; Resident #24's October 2020 MAR for 10/6/20,10/08/20 and 10/12/20 had documented that 3 doses of 5 mg Norco were administered to the resident. There was no documentation to indicate Norco5 mg had been administered on 10/20/2020 at 9:30 PM. Resident #24's controlled substance declining inventory sheet indicated 3 doses of 5 mg Norco were pulled from the medication cart for November 2020 on the following dates: a. On 11/7/20 at 02:57 AM (time unclear), 1 dose of Norco was documented as removed from the med cart; b. On 11/14/20 at 3:37 (time of AM/PM was unclear), 1 dose of Norco was documented as removed from the med cart; c. On 11/29/20 at 5:42 PM, 1 dose of Norco was documented as removed from the med cart. Resident #24 's November 2020 MAR did not document 1dose of 5 mg Norco was administered to the resident on 11/14/2020. Resident # 24's December 2020 MAR did not document 1dose of 5 mg Norco was administered to the resident on 12/8/2020. Interview on 1/13/21 at 11:00 AM via the phone with the consultant pharmacist stated she had not been advised of any issues with controlled	F 755	management, and negative findings will have corrective actions and presented at the next QAPI meeting.	

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substances at the facility.
An interview was conducted on 1/13/21 at 12:30 PM and 1/14/21 at 1:54 PM with the facility's Director of Nursing (DON). During the interview, the DON described the process nursing staff was expected to follow for the administration of a controlled substance pain medication. She expected the nurse to pull the controlled substance medication from the narcotic section of the medication cart, administer the medication and document the administration on both the declining inventory record and the resident's MAR.

Interview on 1/14/21 at 11:15 AM via phone with Nurse #3 stated she no longer worked at the facility and was not sure that she had signed Norco 5 mg on the declining inventory sheet on 10/20/21. Nurse #3 was identified by her initials on the controlled substance declining inventory sheet by the DON as having pulled a dose of Norco for Resident #24.

Interview on 1/14/21 at 1:27 PM with Nurse #4 via the phone stated she was unsure/could not recall about the lack of documentation on the MAR for the administration of the controlled substance Norco. This nurse stated the process was to document on the MAR the medication administered and the pain intensity. Nurse #4 stated it must have been an oversight due to COVID.

Attempts to interview Nurse #5 (who worked 11/14/20) were unsuccessful.

Attempts to Interview resident #24 were unsuccessful.

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F 806	Continued From page 32	F 806		
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 record review, observation, resident, and staff interviews the facility failed to honor the beverage preferences for 1 of 3 residents reviewed for food palatability (Resident #11). Findings Included: Resident #11 was admitted to the facility on 01-15-2016 with multiple diagnoses which included congestive heart failure, hypertension, paraplegia, and Parkinson ' s disease. A review of June 2020 concern revealed Resident #11 voiced a concern on June 19, 2020 with always receiving tea and coffee. A resolution was received from the Administrator on June 30, 2020 and it stated Resident #11 would receive lemonade at lunch meal. The Minimum Data Set (MDS) dated 12-07-2020 for Resident # 11 identified she received a therapeutic diet, needed supervision with eating and her cognition was intact.	F 806	How corrective action will be accomplished for resident(s) found to have been affected: " Facility will honor the beverage preferences for Resident #11. How corrective action will be accomplished for resident(s) having potential to affected by the same issue needing to be addressed: " On 01/12/2021, current resident□s beverage preferences were reviewed by Dietary Manager. If any resident was missing beverage preferences, the resident and/or RP was interviewed to ensure beverage preference was documented. " On 01/20/2021 Dietary Manager and/or designee started re-education to dietary staff regarding procedure to ensure beverage preferences were honored. Education was completed on 01/25/2021. What measure will be put in place or systemic changes made to ensure that	3/19/21

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F 806	Continued From page 33 Observations during lunch meal on 01-11-2021 at 1:00 pm revealed Resident #11 received a glass of tea as the only beverage on her meal tray. She was not served lemonade or skim milk on her meal tray. Review of the meal ticket served with this resident ' s lunch meal revealed her beverages preference included lemonade and skim milk. Observations on 01-12-2021 at 12:20 pm revealed Resident #11 received a glass of tea, a carton of skim milk and a glass of water on her lunch meal tray. She was not served lemonade on her meal tray. Review of the resident ' s meal ticket served with this meal revealed the resident ' s beverage preferences included lemonade and skim milk. An interview with Resident #11 was conducted on 01-12-2021 at 12:15 pm and she stated she had informed the staff on numerous occasions that she was "tired of getting tea every day." An interview was conducted on 01-13-2021 at 1:28 pm with the Dietary Manager. She stated she was not aware Resident #11 preferred to be served lemonade instead of tea at her meals, however she should have received lemonade and skim milk as stated on her lunch meal ticket. An interview was conducted on 01-14-2021 at 12:11 pm with the Director of Nursing (DON) and she stated she was not aware Resident #11 did not want tea with lunch. She indicated Resident #11 should have received the beverages as noted on her meal ticket as she previously requested.	F 806	the identified issue does not occur in the future: " The Dietary Manager will complete a food tray audit 3x per week using the last tray served on the hall to ensure that food is being served to residents at proper temperatures. Food that is not being served at proper temperatures will be returned to the kitchen to be reheated and staff educated. Indicate how the facility plan to monitor its performance to make sure that solutions are achieved and sustained: " Dietary Manager will randomly select 1 tray per meal and audit to ensure beverage preferences were honored 5 x per week, weekly times 1 month, and monthly times 3 months. Dietary Manager and/or designee will report audit findings monthly to the QAPI team for review times 3 months. Documentation of the review will be kept by the Administrator in the QAPI Book. " Ongoing random audits will also be conducted by Administrator and/or nurse management, and negative findings will have corrective actions and presented at the next QAPI meeting.	

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F 812	Continued From page 34	F 812		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain the temperatures of hot foods being served from the kitchen's steam table at 135 degrees Fahrenheit (F.) or higher for five of five resident meals that were observed being prepared from the steam table. Findings Included: An observation was conducted on 1/12/21 at 12:00 pm of the lunch meal service in the kitchen. Monitoring of the temperatures of the foods being served from the steam table revealed the following temperatures: mashed potatoes 140 degrees F, baked chicken 145 degrees F, green	F 812	How corrective action will be accomplished for resident(s) found to have been affected: " On 01/20/2021 Dietary Manager educated cook #1 and Dietary aide #1 regarding procedure for monitoring/documenting hot foods leaving the steam table as well as proper procedure for reheating food items. Education was completed on 01/20/2021. How corrective action will be accomplished for resident(s) having potential to affected by the same issue needing to be addressed: " On 01/2021Dietary Manager and/or	3/19/21

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F 812	Continued From page 35 peas 148 degrees F, vegetable blend 120 degrees F, potato tots 180 degrees F, ground fish 140 degrees F, puree fish 140 degrees F and puree vegetable blend 122 degrees F. Cook #1 was observed to prepare 4 resident meal trays that received the puree vegetable blend and 1 resident meal tray that received the regular vegetable blend. Dietary Aide #1 was observed to place these resident meal trays into a delivery cart and prepared to send the cart to the nursing unit for service to the residents. An interview with Dietary Aide #1 on 1/12/21 at 12:10 pm revealed these five resident meal trays were ready and he would deliver them to the nursing unit to be served. An interview with Cook #1 on 1/12/21 at 12:12 pm revealed when she took the temperatures of the food being served from the kitchen's tray line, they had temperatures that were about 170 degrees F. or higher. She stated the food temperatures needed to be around 140 to 145 degrees F. before they were served from the tray line. Cook #1 stated the temperature of the regular and puree vegetable blend must have dropped while they were preparing meals from the steam table and there really wasn't anything, she could do about this temperature decrease in these foods. She stated it was okay for these meal trays to be served to the residents. An interview with the Dietary Manager (DM) on 1/12/21 at 12:14 pm revealed food temperatures were required to be at least 135 to 140 degrees F. when served from the tray line and these 5 resident meal trays should not be served and needed to be reheated.	F 812	designee started re-education to dietary staff regarding procedure for monitoring/documenting hot foods leaving the steam table as well as proper procedure for reheating food items. Education was completed on 01/25/2021. What measure will be put in place or systemic changes made to ensure that the identified issue does not occur in the future: " The Dietary Manager will review new resident assessments to ensure resident preferences were completed and documented upon admission. Indicate how the facility plan to monitor its performance to make sure that solutions are achieved and sustained: " Dietary Manager will audit temperatures of hot foods being served from the steam table to ensure food was leaving the steam table at 135 degrees Fahrenheit or higher and record temperatures in temperature log 5 x per week, weekly times 1 month, and monthly times 3 months. Hot food with temperatures less than 135 degrees will be reheated to proper temperatures before serving to residents. Dietary Manager and/or designee will report audit findings monthly to the QAPI team for review times 3 months. Documentation of the review will be kept by the Administrator in the QAPI Book. " Ongoing random audits will also be conducted by Administrator and/or nurse management, and negative findings will have corrective actions and presented at the next QAPI meeting.	

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F 812	Continued From page 36 An interview on 1/21/21 at 11:00 am with the Administrator revealed she expected the dietary staff would have reheated the food items to the required service temperature before being served to the residents.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable 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;	F 880		3/19/21

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F 880	Continued From page 37 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §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 observation, record review, staff interviews and physician interview, the facility failed to implement infection control policies when staff working with residents who were on the	F 880	How corrective action will be accomplished for resident(s) found to be affected: Resident # 11 was provided incontinent	

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F 880	Continued From page 38	F 880		

facility's person under investigation (PUI) quarantine unit did not wear personal protective equipment (PPE) including gloves and/or a gown when entering the residents room and/or did not perform hand hygiene for 2 of 3 staff members observed working on the facility's quarantine unit and provided care to residents who were on Enhanced Droplet Isolation precautions (nursing assistant #1 and nursing assistant #2). These failures occurred during the COVID19 pandemic.

Findings included:

1.Review of the facility's "Infection Control Guidelines for All Nursing Procedures" dated August 2012 revealed in part; employees must perform hand hygiene after contact with objects in the immediate vicinity of the resident and wear personal protective equipment as necessary to prevent exposure to potentially infectious materials.

Review of the facility's "Isolation-Categories of Transmission Based Precautions" dated 3-1-20 revealed in part; put on a mask, gown and gloves when entering a resident room.

1a. Observation of the quarantine unit occurred on 1-11-21 at 12:50pm. The unit was noted to have 11 residents who had an "Enhanced Droplet Isolation" sign located on each of their doors. There was one isolation cart on the unit that contained gloves and gowns. The unit was observed to have wall hand sanitizer available throughout the unit.

During the observation of the quarantine unit on 1-11-21 at 12:53pm, nursing assistant (NA) #1 was observed entering Resident #17's room, who

care on 1/13/21.
Resident # 11 was inspected for skin breakdown or any issues associated with not receiving proper perineal care after incontinent episodes.
On 1/13/21 Don in-service NA #6 and Nurse #1 on the perineal care policy.
How corrective action will be accomplished for residents having potential to be affected by the same issue need to be addressed:
100% audit of all residents skin (peri area) was inspected on 1/14/21 for redness or breakdown. Any negative findings were reported to the NP or MD for proper treatment. Any skin issues were reported to the wound NP in the facility for follow up and proper treatment.
On 2/19 the Don will begin in servicing all nurses and CNAs on perineal care of males and females per the company s policy and procedure. In-services will be completed on 3/19.
What measure will be put in place or systemic changes made to ensure that the identified issue does not occur in the future:
All nurses and CNAs will be educated on perineal care policy upon hire or at the beginning of his or her shift if agency.
Indicate how the facility plans to monitor its performance to make sure that solutions are achieved and sustained:
The DON will randomly audit a total of five residents daily Monday through Friday from all three shifts receiving perineal care after an incontinent episode. This will be done weekly x one month, and monthly x three months. Any negative findings will

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F 880	Continued From page 39 was on enhanced droplet precautions without donning gloves, gown or face shield/goggles. NA #1 retrieved a water glass from the residents room, walked out into the hallway to the ice chest without performing hand hygiene, proceeded to touch the lid of the ice chest and ice scooper, filled the residents water glass with ice and returned to the residents room placing the glass back down on the residents table and exiting the room at which time she performed hand hygiene. NA #1 was interviewed on 1-11-21 at 12:55pm. The NA confirmed Resident #17 was on enhanced droplet precautions and that she was required to wear gloves, gown and face shield/goggles when entering the room. She stated, "I did not think about putting on all that PPE since I was just getting him some ice." NA #1 discussed receiving education on isolation precautions, infection control, PPE, and hand hygiene. The Administrator was interviewed on 1-13-21 at 9:00am. The Administrator stated NA #1 had been a long-time employee of the facility and had been trained in infection control, isolation precautions, PPE, and hand washing. She further stated she did not know why the NA would have gone into an isolation room without donning her PPE but that she would re-educate the NA. 1b. Observation of the quarantine unit occurred during breakfast on 1-12-21 at 9:05am. Nursing assistant (NA) #2 was observed assisting other staff to collect the breakfast trays from the resident's rooms who were on enhanced droplet isolation. NA #2 was observed standing in the hall and retrieving a tray from Resident #17's room without donning gloves and placing the tray in the	F 880	be corrected immediately. The results will be reviewed monthly in the QAPI meeting by the interdisciplinary committee and any necessary changes will be made at that time.	

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F 880	Continued From page 40 food cart. NA #2 then opened and closed Resident #22's door and proceeded to retrieve a tray from Resident #23's room and place it in the food cart then performed hand hygiene. NA #2 was interviewed on 1-12-21 at 9:10am. The NA discussed that it was her first day working on the quarantine unit and that she had received education that morning (1-12-21) on isolation precautions and PPE but not on specific hand hygiene. She further discussed not thinking about the possibility of spreading the COVID virus since she had not actually entered the resident rooms. The Administrator was interviewed on 1-13-21 at 9:00am. The Administrator stated NA #2 was not an employee of the facility but was an agency employee. She confirmed the NA had received guidance that morning (1-12-21) regarding the quarantine unit and the need for PPE. The Administrator stated she would re-educate NA #2 on proper hand hygiene and the use of PPE. The facility's Medical Director was interviewed by telephone on 1-14-21 at 1:33pm. The Medical Director discussed the facility having a COVID19 outbreak in November and December that caused most of the residents to contract the COVID virus and stated he felt staff had become less diligent in wearing their PPE and hand washing. He further discussed the new strains of the COVID19 virus and the possibility of infection and the need for staff to continue to follow the set precautions and protocols.	F 880		
F 882 SS=F	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4)(c) §483.80(b) Infection preventionist	F 882		3/19/21

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F 882	Continued From page 41 The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. §483.80 (c) IP participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to have a designated Infection Preventionist (IP), who had completed specialized training in infection prevention and control, to attend monthly Quality Assessment and Assurance committee. Findings included: Review of the facility's Director of Nursing job description dated December 2011 revealed in part; the Director of Nursing was to oversee the	F 882	How corrective action will be accomplished for resident(s) found to have been affected: " The facility has designated a qualified individual as the infection preventionist. 01/14/2021 Christal Spruill RN How corrective action will be accomplished for resident(s) having potential to affected by the same issue needing to be addressed: " The facility has designated a qualified individual as the infection preventionist.	

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F 882	Continued From page 42 employee health program with the medical director and staff development coordinator. The facility did not have an Infection Preventionist job description. During an interview with the Administrator on 1-11-21 at 10:10am, the Administrator stated the facility's Director of Nursing (DON) was the acting Infection Preventionist (IP) but did not have any specialized training in infection prevention and control. She further discussed the facility's corporate consultant who was SPICE trained, was utilized to assist the DON in infection control measures. The Administrator stated the previous IP had terminated employment with the facility in November 2020 and that she had the job posted until the holidays when she removed the job posting. The Administrator discussed she had planned to repost the position after the holidays but as of 1-11-21 the position was not reposted. The Director of Nursing (DON) was interviewed on 1-11-21 at 1:30pm. The DON confirmed she was the acting IP for the facility since the beginning of December. She stated she had not received any specialized training in infection prevention and control. The DON added she believed the facility had been attempting to hire a specialized IP. The facility's corporate consultant was interviewed by telephone on 1-19-21 at 12:09pm. The corporate consultant confirmed she had specialized training in infection prevention and control. She discussed entering the facility 2-4 days a month and that her duties included making sure staff were wearing their PPE, hand hygiene,	F 882	01/14/2021 Christal Spruill RN What measure will be put in place or systemic changes made to ensure that the identified issue does not occur in the future: " The Nursing Home Administrator will continue to designate an individual as the infection preventionist and have an additional employee trained as a backup to this position. Indicate how the facility plan to monitor its performance to make sure that solutions are achieved and sustained: " Nursing Home Administrator will ensure that there is an infection preventionist designated and will retain the job description of this employee, reporting to QAPI monthly. This employee will, 1. Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field (2) Be qualified by education, training, experience or certification, (3) Work at least part-time at the facility (4) Have completed specialized training in infection prevention and control, (5) IP participation on quality assessment and assurance committee.	

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F 882	Continued From page 43 observing the screening process and observing the COVID19 testing process. The corporate consultant also stated she reviewed policy's and procedures and the facility's testing record. She stated she had not attended the Quality Assessment and Assurance committee. She acknowledged the facility did not have a specialized IP and stated the goal was for the facility to hire/train 2 staff members for the IP role. A review of the facility's quality assessment and assurance committee roster from July 2020 to December 2020 revealed, there was not a specialized IP present at the facility's monthly meetings. The facility's medical director was interviewed by telephone on 1-20-21 at 9:41am. The medical director stated he was unaware the facility did not have a specialized trained infection preventionist and stated he was not aware that a facility was required to have a specialized trained infection preventionist.	F 882		
F 886 SS=E	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to:	F 886		3/4/21

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F 886	Continued From page 44 (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing	F 886		

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F 886	Continued From page 45 services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on facility record review, staff interviews, health department interview and physician interview, the facility failed to implement the Centers for Medicare and Medicaid Services (CMS) interim final rule for long term care facility testing of staff for COVID19 based on their county's positivity rate. The facility failed to test staff twice a week for the COVID19 virus based on their county's positivity rate for 3 of 3 weeks (the week of 12-21-20, the week of 12-28-20 and the week of 1-4-21) that testing results were reviewed. This failure occurred during the COVID19 pandemic. Findings included: Review of the facility's COVID19 policy and procedure dated December 2020 revealed in part; each facility should use their county positivity rate in the prior week as trigger for staff testing frequency. Each facility should monitor their county positivity rate every week. Review of the counties positivity rate and the facility's testing report for the week of 12-21-20 revealed a county positivity rate of 10.0 which required the facility to test staff for the COVID19 virus twice the week of 12-21-20 according to the CMS interim final rule. The facility's testing report	F 886	How corrective action will be accomplished for resident(s) found to have been affected: • On 01/14/2021, Corporate Consultant educated DON on how to check county positive rates for COVID Testing Frequency to ensure understanding. How corrective action will be accomplished for resident(s) having potential to affected by the same issue needing to be addressed:¿ • On 01/19/2021, Corporate Consultant educated DON on CMS Final Interim rule to ensure understanding. • On 01/19/2021, Corporate Consultant educated DON on corporate policy/procedure for rapid test use when lab is down for staff testing. • Frequency of Staff COVID testing will be performed based on county positivity rate during the COVID 19 pandemic and CMS interim final rule. What measure will be put in place or systemic changes made to ensure that the identified issue does not occur in the future: • The DON or administrator will check CMS website for county positivity rate	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA PINES AT GREENSBORO, LLC	109 S HOLDEN RD GREENSBORO, NC 27407

(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 886	Continued From page 46 revealed staff were tested once the week of 12-21-20. Review of the counties positivity rate and the facility's testing report for the week of 12-28-20 revealed a county positivity rate of 10.2 which required the facility to test staff for the COVID 19 virus twice the week of 12-28-20. The facility's testing report revealed staff were tested once the week of 12-28-20. Review of the counties positivity rate and the facility's testing report for the week of 1-4-21 revealed a county positivity rate of 13.1 which required the facility to test staff for the COVID 19 virus twice the week of 1-4-21. The facility's testing report revealed staff were tested once the week of 1-4-21. During an interview with the Administrator on 1-11-21 at 10:10am, the Administrator stated the facility did not have any COVID positive residents and their last COVID positive resident was 12-16-20. She also discussed the possibility of having one COVID positive staff member but stated the results of the staff members test was conflicting. The Administrator said the facility was testing staff twice a week. A nursing assistant (NA) #1 was interviewed on 1-11-21 at 12:50pm. NA #1 confirmed she was a full-time employee of the facility and received a COVID19 test weekly on Monday's or Tuesday's. She further stated she had not received a COVID19 test twice a week since the first week of December 2020 (the week of 11-30-20). During an interview with a certified medication aid (CMA) #3 on 1-11-21 at 3:00pm, the CMA	F 886	weekly prior to beginning COVID testing on staff and/or residents and document positivity rate until the conclusion of the pandemic or until instructed otherwise by CMS. • The DON or administrator will complete an audit each week to ensure that working staff receive required number of COVID tests required by CMS interim final rule. • Frequency of Staff COVID testing will be performed based on county positivity rate during the COVID 19 pandemic and CMS interim final rule. Indicate how the facility plan to monitor its performance to make sure that solutions are achieved and sustained: • DON /Administrator will randomly audit COVID test 5 x per week, weekly times 1 month, and monthly times 3 months. DON or administrator will report audit findings monthly to the QAPI team for review times 3 months. Documentation of the review will be kept by the Administrator in the QAPI Book. • Ongoing random audits will also be conducted by DON or Administrator and negative findings will have corrective actions and presented at the next QAPI meeting.	

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F 886	Continued From page 47	F 886		

confirmed she was a full-time employee of the facility and stated she received a COVID19 test weekly on Tuesday's.

The activities director was interviewed on 1-11-21 at 3:15pm. The activities director discussed being a full-time employee of the facility and received a COVID19 test twice a week. She explained the twice a week testing had started the week of 1-11-21 and prior to week 1-11-21 she had received the COVID19 test one time a week for the weeks of 12-21-20, 12-28-20 and 1-4-21.

NA #4 was interviewed on 1-12-21 at 8:45am. NA #4 discussed being a full-time employee of the facility and stated she received the COVID19 test twice a week. She further commented that prior to the week of 1-11-21, she received a COVID test weekly.

During an interview with a physical therapy assistant (PTA) #5 on 1-12-21 at 10:05am, the PTA discussed being a full-time employee of the facility and stated she received a COVID19 test twice a week. She also commented that prior to the week of 1-11-21, she had received the COVID19 test once a week.

The Administrator was interviewed on 1-13-21 at 9:00am. The Administrator reviewed the staff testing report binder and acknowledged the facility was required to test staff twice for the COVID19 virus the week of 12-21-20 but stated the week of 12-21-20 was a holiday week and the facility was unable to test the staff twice because the lab was closed over the holiday. She discussed not being able to use the rapid tests that were available for staff because it was company policy that the rapid tests were to be

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F 886	Continued From page 48	F 886		

used for the residents. She acknowledged the facility had rapid tests available that could have been performed on staff. The Administrator discussed the week of 12-30-20 and stated the facility conducted testing on staff one time that week due to the counties positivity rate at 10.0. She stated she was unaware that the facility needed to test twice because the counties positivity rate had not been 10 or below for a consecutive 2 weeks. The Administrator discussed the week of 1-4-21 and stated the facility had tested staff for the COVID19 virus one time that week. She explained she had not checked the counties positivity rate until 1-6-21 and then realized the facility should have tested the staff twice the week of 1-4-21.

During an interview with the facility's Regional Director of Operations (RDO) on 1-13-21 at 1:15pm, the RDO confirmed the facility did not perform the COVID19 tests on the staff twice the week of 12-21-20 due to the holiday and the lab was not open. She further confirmed the facility's policy on the rapid tests were for the residents and not to be used on the staff.

The facility's medical director was interviewed by telephone on 1-14-21 at 1:33pm. The medical director stated he was not aware the facility was not following the testing guidelines and he would speak with the Administrator to assist in developing an effective testing schedule.

An interview occurred with the facility's Corporate Consultant by telephone on 1-19-21 at 12:09pm. The consultant discussed being present in the facility 2-4 days a month. She discussed when she was in the building, she would review the staff testing record. The consultant stated she

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F 886	Continued From page 49 was not aware the facility was not testing per the counties positivity rate. She explained the week of Christmas (12-21-20) and the week of New Year's (12-28-20), the facility had tested staff one time because the lab was closed for the holidays. The consultant further stated the facility had contacted the local health department about the lab being closed and was advised to test staff one time the week of 12-21-20 and 12-28-20. During an interview by telephone with the local health department nurse on 1-19-21 at 3:22pm, the health department nurse stated she did not remember the conversation with the facility but if a facility informed her the lab they used for testing was closed, she may have told them to only test once so the second testing would not expire. She further stated if a facility had rapid tests available, the facility should have used the rapid tests on the staff instead of forgoing testing.	F 886		
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 observation, record review, resident and staff interview the facility failed to have an effective pest control program to promote a free environment from crawling insects. This was evident in 1 of 2 resident care floors. (2nd floor) Findings included: Record review of the "Customer Service Report" from the contracted pest company revealed on	F 925	How corrective action will be accomplished for resident(s) found to have been affected: " Pest control treatment was performed on room 225, 231, 224, 225 and their respective in-room bathrooms by Maintenance Director on 01/14/2021 " Another pest control treatment was performed by Pest Control Company on 02/02/2021 of the interior areas of the	3/19/21

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F 925	Continued From page 50 11/30/20 and 12/21/20 there were no issues observed. Record review of the pest control log books revealed no sightings of pest. Record review of Resident #1's significant change Minimum Data Set (MDS) assessment dated 12/11/20 coded a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact. Interview on 01/12/21 at 2:18 PM with Resident #1 who resided on the facility's 2nd floor, stated she observed "live roaches in her room" on 1/11/21. She specified, they would crawl under her dresser that the television sits on. At the time of the interview, the dresser was moved, and one live brown colored crawling insect and one dead brown colored insect was observed. Interview on 1/13/21 at 2:04 PM with the administrator stated she had not had any reports from residents or staff of cockroaches or bugs in the building and thought it was time for the extermination company ' s monthly visit. Another interview on 01/14/21 at 1:15 PM with the administrator stated the contracted Housekeeping Director (HKD) was responsible for pest control until a Maintenance Director (MD) was hired and working. Interview on 01/14/21 at 1:25 PM with HKD stated he was not responsible for pest control in the facility. Observation on 01/14/21 at 3:00 PM with the current MD revealed a live brown colored	F 925	building. How corrective action will be accomplished for resident(s) having potential to affected by the same issue needing to be addressed: " On 01/13/2021 the Maintenance Director completed an audit of 2nd floor resident rooms and in-room bathrooms to ensure compliance to the policy to maintain an effective pest control program. If any pests were found, the Maintenance Director documented findings in Pest Sighting Log Book and addressed the problem immediately. " On 01/13/2021, the Maintenance Director and/or designee started re-education to facility staff regarding the procedure for notifying maintenance of any sightings of pests. Staff are educated to document sightings/findings in Log Book and to notify immediate supervisor. Education will be completed on 03/19/2021. " Maintenance Director checks Pest Sighting Log Book 5 days per week. What measure will be put in place or systemic changes made to ensure that the identified issue does not occur in the future: " The Maintenance Director/or designee will complete a Pest Control audit of all resident rooms and resident bathrooms to ensure an effective pest control program 5 days per week, then weekly times one month, then monthly times three months. " The Maintenance Director/or designee will complete an audit of the Pest Control Log Book to ensure staff are	

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F 925	Continued From page 51 crawling insect in Room 225. Interview on 1-14-21 at 10:41 AM with Housekeeper #1 stated had not seen any bugs on the 2nd floor for the past 2 months but will see some in Room #231 bathroom occasionally. Stated when he sees any bugs, he tells maintenance so they can call the exterminator. Interview on 1/14/21 at 10:50 AM with Physical Therapist Assistant #5 (PTA) who stated a "cockroach" was seen yesterday (referring to 1/13/21) in the bathroom of Room 224. The PTA stated she told the housekeeper and the housekeeper took care of it immediately by notifying the MD. Continued interview stated when any bugs are observed, she lets housekeeping and/or maintenance know. .Interview on 1-14-21 at 11:40 AM with MD stated the process for staff to report pest is to write it in the pest book and/or maintenance log. When he looks at the maintenance log and sees it is a pest issue, he calls the pest control company to come out that day or within a couple days. . Stated for the roach seen on Monday (1/11/21), he had called the pest company and will followed up with them this morning (1/14/21) Observation on 1/14/21 at 3:00 PM and witnessed by the MD revealed in the bathroom of Room #225 revealed a live brown colored crawling insect on the floor. Interview on1/14/21 at the time of the sighting in Room #225's bathroom with the MD revealed she just started employment at the end of December 2020 and was unclear of who was responsible for pest control in the facility.	F 925	notifying maintenance of any sightings of pests and issues have been resolved 5 days per week, then weekly times one month, then monthly times three months. Indicate how the facility plan to monitor its performance to make sure that solutions are achieved and sustained: " Administrator will review the Pest Control audit tools 5 x per week, weekly times 1 month, and monthly times 3 months, to ensure pest control reporting and treatment is effective and report audit findings monthly to the QAPI team for review times 3 months. Documentation of the review will be kept by the Administrator in the QAPI Book. " Ongoing random audits will also be conducted by Administrator and/or nurse management, and negative findings will have corrective actions and presented at the next QAPI meeting.	