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E 000	Initial Comments An unannounced Recertification survey was conducted from 03/01/21 through 03/05/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #KXZL11.	E 000		
F 000	INITIAL COMMENTS A recertification survey was conducted from 03/01/2021 through 03/05/2021. Immediate Jeopardy began on 2/27/2021 and was removed on 2/28/2021. Past noncompliance was identified at: CFR 483.12 at tag F600 at a scope and severity J The tag F600 constituted Substandard Quality of Care. An extended survey was conducted.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;	F 600		3/18/21

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

Electronically Signed | 03/26/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 600	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interviews, physician interview and record review the facility failed to ensure a resident was free of physical abuse for 1 of 3 residents reviewed for allegations of abuse (Resident #61). This occurred when Nurse Aide #2 slapped Resident #61 with an open hand twice on the left side of the head and hit Resident #61 once with a closed fist in a facility hallway. The physical abuse resulted in Resident #61 having a red mark on the left side of his head. The findings included: Resident #61 was admitted to the facility on 4/19/19. Resident #61's annual Minimum Data Set assessment dated 2/15/21 revealed he was assessed as cognitively intact. He was assessed to have adequate hearing, clear speech and was able to make himself understood by others. He had no behaviors during the look back period. Resident #61's active care plan initiated on 9/23/20 revealed he was care planned for ineffective coping with verbal/physical behavior. The interventions included for Resident #61 to receive behavior management and psychiatric consults, give medication as prescribed by the physician, and remove resident from public area when behavior is disruptive. He was also care planned for resistance to treatment and care related to inappropriate behavior. During an interview with Resident #61 on 3/2/21 at 4:05 PM he stated on 2/27/21 at 8:05 PM he	F 600	Past noncompliance: no plan of correction required.	

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was in the hallway ambulating with his electric wheelchair when he observed two female residents calling out. He stated he notified Nurse Aide #1 (NA #1) that he had observed two female residents calling out for help. Resident #61 stated while he was speaking with NA #1 another nurse aide, Nurse Aide #2 (NA #2), walked by them. He reported NA #2 stated he needed to stop being a hall monitor and mind his own business. Resident #61 stated he told NA #2 he was not speaking with her and she needed to go back to work. He reported a verbal altercation occurred and NA #2 began to approach him. Resident #61 stated he then asked NA #2 to leave him alone and she asked, "what he was going to do about it." He stated he spit at NA #2 and she slapped him with an open hand twice on his head. Resident #61 reported NA #2 also struck him with a closed fist on the left side of his head. He then said he was unsure if he spit at her prior to her striking him or after she hit him. Resident #61 stated he contacted the police.

An interview was conducted with NA #1 on 3/3/21 at 10:56 AM who stated she was working on 2/27/21 and Resident #61 was one of her assigned residents. She stated at approximately 8:05 PM Resident #61 approached her and stated two residents down the hall needed assistance. She reported that while she was speaking with the resident, NA #2 approached them and stated to the resident, he needed to mind his own business. As NA #2 continued walking towards the 600 hall Resident #61 told her NA#2 needed to do her job. NA #1 stated they began arguing loudly. NA #2 turned around to come closer to the Resident. NA #1 stated she observed NA #2 strike Resident #61 three or four times on the left side of his head. She stated she

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told NA #2 to stop and she did so. NA #1 stated NA #2 said the resident spit on her. She reported she did not witness any spitting. NA #1 indicated she did not require any assistance from NA #2 during this interaction with Resident #61. She stated Resident #61 left the area in his electric wheelchair. NA #1 stated she found Nurse #1 to report what happened.

An interview was conducted with NA #2 on 3/3/21 at 12:32 PM. She reported on 2/27/21 at approximately 8:05 PM she saw Resident #61 in the hallway. NA #2 stated that Resident #61 liked to be "the hall monitor" and tell people how to do their jobs. She stated she told Resident #61 to go back to his room and "mind his business". NA #2 stated Resident #61 called her a profane name (b-----) and asked who she was talking to. NA#2 stated she replied she was talking to him. NA #2 stated Resident #61 pursued her and spit on her. She stated she slapped him with an open hand to the left side of his face. NA #2 stated Resident #61 spit on her again and she slapped him again with an open hand to the left side of his face. NA#2 then stated he spit on her a third time, so she struck him with a closed fist on the left side of his head. NA #2 stated, "I hit him with a closed fist because obviously he was not getting my drift and the slaps were not working. When I hit him, he stormed off to the lobby to call the police". NA #2 stated she went outside and contacted the Administrator while Resident #61 contacted the police. She stated she went to her assigned unit and told Nurse #1 about the altercation. She stated she then left the unit to wait for the police. NA #2 stated this was her third encounter with Resident #61, but he had never spit at her before. She reported that he had yelled and been disrespectful. NA #2 stated

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she was told he had spit on other staff members in the past.

Review of a witness statement completed by NA #2 dated 2/27/21 read in part, "After speaking with the police and the Administrator, I left the facility. I was trained on abuse, the definition and trained to not to hit a resident. I did not walk away because he spit on me and it was just a reaction."

An interview was conducted with Nurse #1 on 3/4/21 at 9:02 AM. She reported that on 2/27/21 at approximately 8:05 PM she was informed by NA #2 that she had struck Resident #61. She indicated she advised NA #2 to leave the hall to await the police. Nurse #1 stated she did not see the incident. She stated NA #2 left the 600 hall to get linens. Nurse #1 stated Resident #61 was not on NA #2's assignment and wasn ' t sure how the incident occurred. Nurse #1 stated she then went and assessed Resident #61 for injury. She reported he described the incident to her and stated he was fine. Nurse #1 stated she assisted Resident #61 in contacting his family.

Review of a police report dated 2/27/21 revealed police officers were dispatched to the facility at 8:13 PM for a possible assault that occurred between a resident and caregiver. The report stated the officer was met outside the facility by NA #2 who stated she was "fed up" with Resident #61. The report revealed NA #2 told the officer Resident #61 spit on her and she slapped him. NA #2 further reported every time he spit on her she slapped him. The report stated Resident #61 was interviewed and he stated NA #2 "came at him and hit him for being involved in someone

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else's business." According to the report both parties refused to press charges. The report stated the Administrator was interviewed and stated the matter would be handled internally. The officer's report indicated NA #2 left the facility prior to law enforcement leaving the facility.

An interview was conducted with the Medical Director of the facility on 3/3/21 at 2:40 PM who stated he was contacted on the evening of 2/27/21. He reported he was advised that Resident #61 spit on a staff person and Resident #61 was assaulted. The Medical Director stated he examined Resident #61 on 3/2/21 and saw no lingering evidence of injury. He stated that the aide was provoked, and she should have walked away. He further stated Resident #61 was provocative but that does not excuse striking him.

An interview was conducted with the Administrator on 3/3/21 at 3:15 PM who stated he spoke with NA #2 on the evening of 2/27/21 after she had spoken with the police. The Administrator indicated he was contacted by NA #2 via phone that she had struck a resident. He stated he advised her to wait for the police outside the facility and drove to the facility. He stated that she left the facility after being interviewed by himself and Corporate Consultant #1. The Administrator stated he had not advised NA #2 of her termination, but she would not be allowed back in the facility.

The facility provided a corrective action plan with a correction date of 2/28/21. The corrective action plan included F600.

F 600-Abuse

· Recipients who have suffered or are

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likely to suffer, a serious adverse outcome as a result of the non-compliance

On 2/27/2021, 100% skin checks were initiated on all residents who are unable to report signs/symptoms of abuse by the hall nurse and will continue to be completed by the treatment nurse, and/or director of nursing. A skin check assessment tool will be utilized with documentation in the electronic medical record. The skins checks will be completed by 2/28/21.

On 2/28/21, 100% of all alert and oriented residents will be interviewed by the Nursing Supervisor in regards to: Do you know what abuse means? Are there any instances that you felt you were abused in any way that has not bee addressed? Do you know who to report abuse to? Do you feel safe here?

On 2/28/21, education will be initiated and completed with 100 % of all alert and oriented residents by the Nursing Supervisor regarding abuse to include the definitions, resident rights, what to do in an abusive situation and how to report abuse. The education will be complete on 2/28/21.

· Actions taken to alter the process or system failure to prevent a serious outcome for occurring or recurring

On 2/27/21, a questionnaire was initiated by the Administrator and will continue to be completed by the Corporate Consultants and Nursing Supervisors with 100% of all staff to include nurses, nursing assistants, medication aides, dietary staff, housekeeping staff, therapy staff, Administrator, Admissions Coordinator, Accounts

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Receivable, Account Payable, Activities Director, Medical Records, Central Supply Clerk, Maintenance Director, Social Worker and receptionist regarding: Do you know of any resident that you have witnessed or that has been reported abuse to you that has not been addressed? If yes: Please explain. The questionnaire will be completed by 2/28/21. After 2/28/21 any staff that has not worked and not completed the questionnaire will complete prior to the start of next scheduled shift. The DON and Nursing supervisors are responsible to ensure that staff receive the questionnaire prior to the next scheduled shift.

On 2/28/21, 100% of staff to resident interaction observations will be initiated with all staff to include nurses, nursing assistant, medication aides, dietary staff, housekeeping staff, therapy staff, Administrator, Admissions Coordinator, Accounts Receivable, Account Payable, Activities Director, Medical Records, Central Supply Clerk, Maintenance Director, Social Worker, and receptionist by the Corporate Consultant, Director of Nursing, and Nursing Supervisors. The purpose of the interactions are to ensure that residents remain free form abuse when interacting with staff. The interactions will be completed by 2/28/21. After 2/28/21 any staff that has not worked and not been observed interacting with residents, will have observation completed during next scheduled shift. The DON and Nursing supervisors are responsible to ensure that the interactions are completed prior to the start of the next scheduled shift.

On 2/27/2021, an in-service was initiated by the Administrator and will continue to be completed by the Corporate Consultants and Nursing

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Supervisor with 100% of all staff to include nurses, nursing assistant, medication aides, dietary staff, housekeeping staff, therapy staff, Administrator, Admissions Coordinator, Accounts Receivable, Account Payable, Activities Director, Medical Records, Central Supply Clerk, Maintenance Director, Social Worker and receptionist regarding burn out, abuse and what to do when residents display aggressive behaviors. The in-service included the definition of physical abuse and the consequences if found guilty of abuse. In-services to be completed by 2/28/2021. After 2/28/21, the Administrator will ensure the in-services are mailed to any remaining staff who has not worked and not received the in-service with instructions to review, sign the in-service and return to the staff facilitator or Director of Nursing prior to next scheduled work shift.

On 2/28/21, Abuse Quizzes will be initiated by the Corporate consultants and Nursing Supervisors with 100% of all staff to include nurses, nursing assistants, medication aides, dietary staff, housekeeping staff, therapy staff, Administrator, Admissions Coordinator, Accounts Receivable, Accounts Payable, Activities Director, Medical Records, Central Supply Clerk, Maintenance Director, Social Worker and receptionist. The quizzes included questions in regards to (1) What to do immediately if you witness a resident being abused? (2) Who should you report abuse? (3) If a resident becomes combative or aggressive what should you do? (4) If you witness abuse when do you report it? (5) Who is the abuse officer/coordinator? (6) What are the consequences if you are found guilty of abuse? The purpose of the abuse quizzes are to ensure that all staff display successful knowledge and

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understanding of the abuse in-services. The abuse quizzes will be completed by 2/28/21. After 2/28/21, any remaining staff that has not worked and not received the quizzes will complete upon next scheduled shift. The DON and Nursing supervisors are responsible to ensure that staff receive the quiz prior to the start of their next scheduled shift.

On 2/27/21 and 2/28/21, Resident #61 was offered 1:1 observation for emotional support and psychiatric services, however resident declined and stated he felt safe.

Fax cover sheets were reviewed from attempts to fax the initial report to the Department of Health and Human Services from 2/27/21 at 11:19 PM, 2/28/21 at 11:38 AM and 2/28/21 at 2:47 PM. The report was successfully faxed on 3/1/21 at 9:00 AM.

· The procedure for monitoring the plan of correction

10 Abuse/burn out Quizzes will be completed by the Nursing Supervisors, Staff Facilitator and/or Quality Assurance Nurse with staff weekly x 4 weeks. The quizzes are to ensure staff maintain knowledge and understanding of burn out, the abuse policy, reporting abuse, protection of the resident, and how to deal with aggressive residents. Staff will be immediately retrained during the quiz for any identified areas of concern. The DON will review and initial the abuse quizzes weekly X 4 weeks for completion and to ensure all areas of concern are addressed.

The DON will present the Abuse/burn out Quizzes

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F 600	Continued From page 10 to the Executive Quality Assurance Performance Improvement (QAPI) committee monthly for 1 month. The Executive QAPI Committee will meet monthly for 1 month and review the Abuse/burn out Quizzes to determine trends and/or issues that may need further interventions put into place and to determine the need for further monitoring. · The title of the person responsible for implementing the plan of correction The Administrator and Director of Nursing are responsible for the implementation of corrective actions including all 100% audits, in-service and monitoring related to the plans of correction. Quality Assurance Meetings were held on 2/27/21 and 2/28/21 to discuss the plans of correction related to abuse. Date of corrective action plan completion: 2/28/21 The plan of correction was verified through review of verification of education provided to both residents and staff, a review of the audits and monitoring documentation and quality assurance meeting minutes. Staff interviews verified the education provided. The facility's date of compliance of 2/28/21 was verified.	F 600		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:	F 641		4/12/21

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F 641	Continued From page 11 Based on staff interviews and record review the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of preadmission screening resident review (PASSR), bathing and anticoagulant medication for 4 of 18 residents whose MDS assessments were reviewed (Resident #61, Resident #40, Resident #33, and Resident #6). The findings included: 1. Resident #61 was admitted to the facility on 4/19/19 with diagnoses that included quadriplegia, bipolar disorder and borderline personality disorder. Review of PASSR Level II Determination dated 1/4/21 revealed Resident #61 was assessed as requiring specialized services due to his physical and mental health needs. Resident #61's annual minimum data set assessment dated 2/15/21 was coded as other related conditions requiring specialized services. An interview was conducted with MDS Nurse #1 and MDS Nurse #2 on 3/4/21 at 2:37 PM. MDS Nurse #2 stated the question should have been coded as mental health rather than other related conditions. During an interview with the Director of Nursing on 3/5/21 at 9:00 AM she stated MDS assessments should be coded to accurately reflect resident's status and care received. 2. Resident #40 was admitted to the facility on 1/27/21 with diagnoses that included Alzheimer ' s disease.	F 641	Ayden Court Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Ayden Court Nursing and Rehabilitation Center response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Ayden Court Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. On 3/4/21, The Minimum Data Set (MDS) nurse completed a significant correction to prior comprehensive assessment for Resident # 61 to reflect accurate coding for Preadmission Screening Resident Review (PASSR). On 3/19/21, The MDS nurse completed a significant correction to prior comprehensive assessment for Resident # 33 and resident # 40 to reflect accurate coding for ADLs to include showers/baths.	

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F 641	Continued From page 12 Resident #40's admission minimum data set assessment dated 2/3/21 was coded bathing did not occur during the 7-day look-back period of the assessment. An interview was conducted with MDS Nurse #1 and MDS Nurse #2 on 3/4/21 at 2:37 PM. MDS Nurse #2 stated the information in the chart reflecting care provided indicated bathing did not occur. During an interview with the DON on 3/5/21 at 9:00 AM she reported she was certain this was a coding error as Resident #40 received assistance with bathing during her therapy. She indicated the MDS nurses should have interviewed staff prior to coding Resident #40 did not receive baths during the lookback period. 3. Resident #33 was admitted to the facility on 10/26/07 with diagnoses that included heart failure and hypertension. Resident #33's quarterly minimum data set assessment dated 1/27/21 was coded bathing did not occur during the 7-day look-back period of the assessment. During an interview with Resident #33 on 3/1/21 at 3:30 PM she stated she always receives assistance with personal care by staff. She indicated she was not aware of a time where she did not receive her scheduled bath. An interview was conducted with MDS Nurse #1 and MDS Nurse #2 on 3/4/21 at 2:37 PM. MDS Nurse #2 stated the information in the chart reflecting care provided indicated bathing did not	F 641	On 3/9/21, The MDS nurse completed a significant correction to prior comprehensive assessment for Resident # 6 to reflect accurate coding for use of anticoagulants. On 3/26/21, 100% audit of section A for all residents most current MDS assessment; to include resident # 61, was completed by the Facility Consultant and MDS Coordinator to ensure all MDS assessments were coded accurately for the resident Preadmission Screening Resident Review (PASSR). The MDS nurse completed modifications for all concerns identified during the audit. On 3/19/21, 100% audit of section G for all residents most current MDS assessment, to include resident # 33 and resident # 40 was completed by the MDS Consultant to ensure all MDS assessments completed are coded accurately for ADLs to include showers/baths. The MDS nurse completed modifications for all concerns identified during the audit. On 3/19/21, 100% audit of section N for all residents most current Minimum Data Set (MDS) assessment; to include resident # 6, was completed by the MDS Consultant, to ensure all MDS assessments completed are coded accurately to include use of anticoagulants. The MDS nurse completed modifications for all concerns identified during the audit.	

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F 641	Continued From page 13 occur. An interview was conducted with NA #5 who stated she gave Resident #33 her bath as scheduled during her assigned shifts in January. She indicated she must have forgotten to document the baths. During an interview with the DON on 3/5/21 at 9:00 AM she reported she was certain this was a coding error. She indicated the MDS nurses should have interviewed staff prior to coding no baths were given to Resident #33. 4. Resident #6 was re-admitted to the facility on 02/05/2021 with diagnoses including long term anticoagulant use. A review of her discharge minimum data set (MDS) assessment dated 02/23/2021 indicated she did not receive any anticoagulant medication during the seven day look back period for this assessment. A review of Resident #6's current care plan indicated a focus area of potential for bleeding related to anticoagulant use with a goal of will be free from bleeding. This was last revised on 12/23/2020. The target date was 05/24/2021. A review of the February 2021 Medication Administration Record (MAR) for Resident #6 indicated she was administered Eliquis (an anticoagulant medication) 5 milligrams twice daily from 02/6/2021 through 02/24/2021. On 03/03/2021 at 2:27 PM an interview with MDS Nurse #1 indicated she completed the medication section of the discharge MDS for Resident #6 dated 02/23/2021. MDS Nurse #1 went on to say	F 641	On 3/9/21, a 100% in-service was completed by the Administrator with the MDS Coordinator and MDS nurse in regards to on MDS Assessments and Coding per the Resident Assessment Instrument (RAI) Manual with emphasis on completing assessment accurately and completely. All newly hired MDS Coordinator and/or MDS nurse will be in-serviced by the Staff Development Coordinator during orientation in regards to MDS Assessments and Coding. 10% audit of all resident□s to include resident # 6, # 33, # 40 and # 61 most recent MDS assessments section A , G and N will be completed by the Director of Nursing utilizing the MDS Accuracy Tool weekly x 4 weeks then monthly x 1 month. This audit is to ensure accurate and complete coding of the MDS assessment to include section A for PASSR, G for ADL care/bathing and N for use of anticoagulants. The MDS Coordinator and DON will address all areas of concern identified during the audit to include retraining of the MDS nurse and completing necessary assessment of the resident. The Administrator will review and initial the MDS Accuracy Tool weekly x 4 weeks then monthly x 1 month to ensure any areas of concerns were addressed. The DON will forward the results of MDS Accuracy Tool to the Executive Quality Assurance Performance Improvement Committee (QAPI) monthly x 2 months. The Executive QAPI Committee will meet	

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F 641	Continued From page 14 the MDS was incorrect and should have reflected Resident #6's anticoagulant use during the look back period. She further indicated she must have just missed it. On 03/03/2021 at 2:30 PM an interview with the Administrator indicated resident's MDS assessments should be accurately completed to reflect the care that was provided to them.	F 641	monthly x 2 months and review the MDS Accuracy Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
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 observations, resident and staff interviews and record review the facility failed to provide nail care for 1 (Resident #34) of 2 residents who were dependent on facility staff for activities of daily living (ADLs). The findings included: Resident #34 was admitted to the facility on 11/01/17 and was readmitted to the facility on 1/21/21 after hospitalization. Her diagnoses included pneumonia, dementia, and dysphagia. A review of the quarterly Minimum Data Set (MDS) dated 1/28/21 revealed Resident #34 was moderately cognitively impaired. She was totally dependent on staff for bathing, personal hygiene, and dressing. She required extensive assistance with toileting and was always incontinent of bowel and bladder.	F 677	On 3/4/21, the assigned nursing assistant under the oversight of the Director of Nursing nurse provided nail care to resident #34 per resident preference. On 3/4/21, the Director of Nursing initiated an audit of all resident's nail care to include resident # 34. This audit is to ensure all nails are clean and trimmed per resident preference. The hall nurse and nursing assistant addressed all areas of concern identified during the audit to include providing nail care and updating care plan for resident preference. Audit was completed on 3/4/21. On 3/16/21, the Staff Development Coordinator initiated an in-service with nurses and nursing assistants (NA) to include NA # 3 and NA # 4 in regards to Nail Care to include but not limited to cleaning and trimming nails per resident	4/12/21

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F 677	Continued From page 15 The care plan updated 12/13/20 indicated Resident #34 was resistive to treatment related to poor judgement, urinated on self, and refused to be changed. The interventions included allow flexibility in ADL routine to accommodate resident's mood and to document care being resisted. During an observation on 3/1/21 at 4:47 PM Resident #34's fingernails on the right hand had black debris under all the nails. Resident #34's left hand was under the bedspread and could not be observed. On 3/2/21 at 3:46 PM Resident #34 was resting in bed. An observation of the fingernails on both hands revealed all fingers had black debris under each of the nails. On 3/3/21 at 4:20 PM an observation of the fingernails of both hands revealed thy continued to have black debris under all the fingernails. A review of the ADL documentation summary report dated 3/4/21 at 8:11 AM revealed Resident #34 received a full bath on 3/3/21 documented at 1:23 PM by Nursing Assistant (NA) #3. On 3/4/21 at 11:15 AM NA #4 observed Resident #34's fingernails and stated they needed to be cleaned. He stated he had not given her a bath today, but he had cleaned her hands prior to the meals on the days he worked including this morning. He stated the dirty fingernails should have been noted and cleaned. On 3/4/21 at 11:20 AM the Director of Nursing observed Resident #34's fingernails and said the	F 677	preference. In-service will be completed by 4/12/21. All newly hired nurses and nursing assistants will be in-serviced by the Staff Development Coordinator during orientation in regards to Nail Care. The Administrative Nursing Staff will monitor 10 residents nail care to include resident # 34 utilizing the Nail Care Audit Tool weekly x 4 weeks then monthly x 1 month to ensure that resident's nails are cleaned and trimmed per resident preference. The hall nurse or nursing assistant will address all areas of concern identified during the audit to include clean and trimming nails per resident preference and updating care plan for any new resident preference. The Director of Nursing and/or Administrator will review and initial the Nail Care Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all areas of concern were addressed. The DON will forward the results of the Nail Care Audit Tool to the Quality Assurance (QA) Committee monthly for two months. The QA Committee will meet monthly for two (2) months and review the Nail Care Audit Tool to determine trends and/or issues that may need further interventions put into place and determine the need for further and/or frequency of monitoring.	

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F 677	Continued From page 16 fingernails were obviously dirty and needed to be cleaned. On 3/4/21 at 11:20 AM Resident #34 stated she wanted a bath and she wanted her fingernails cleaned. During an interview with NA #3 on 3/4/21 at 2:00 PM she stated she gave Resident #34 a full bath yesterday (3/3/21) and she even applied lotion. She stated cleaning fingernails was one of the tasks included in a full bath, but she did not clean Resident #34's fingernails. She said Resident #34 did not refuse getting a bath and was not resistant to care on 3/3/21.	F 677		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.	F 732		4/12/21

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F 732	Continued From page 17 (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on interviews and record review the facility failed to post accurate staffing information as compared to the daily assignment and failed to post complete staffing with no missing information for 5 of 20 staffing sheets reviewed. The findings included: On 3/5/21 at 9:30 AM a review of the Daily Nurse Staffing (DNS) sheets located in the facility notebook revealed the DNS sheet dated 7/19/20 documented there were 5 Nursing Assistants (NAs) who worked on the 3:00 PM -11:00 PM shift. The review of the Assignment Sheet (The documentation of the staff who actually worked on each shift during each day.) dated 7/19/20 revealed there were only 4 NAs assigned during the shift. Additional reviews of the staffing sheets in the facility notebook on 3/5/21 at 9:30 AM revealed	F 732	On 3/5/21, The Director of Nursing immediately reviewed current posted Daily Nursing Staff Sheet to ensure staffing sheet complete and all information current and accurate. On 3/8/21, 100% audit of the Daily Staffing Sheets for the past 30 days was initiated by the Scheduler to ensure all sheets were completed accurately to include facility name, date, census, total number and actual hours worked by the registered nurse, licensed practical nurse, and certified nurse aides. The Scheduler will addressed all areas of concern identified during the audit. Audit will be completed by 4/12/21. On 3/26/21, the Facility Consultant initiated an in-serviced with the Administrator, Director of Nursing (DON), Scheduler, Receptionist and Nurse Supervisor in regards to Posting of Daily	

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F 732	Continued From page 18 the DNS sheets on 7/20/20 indicated there were 8 NAs on the 7:00 AM- 3:00 PM shift but the assignment sheet revealed there were only 6. On 7/20/20 on the 3:00 PM -11:00 PM shift the DNS sheet indicated there was 1 Registered Nurse (RN). The Licensed Practical Nurse (LPN) line was blank. The assignment sheet revealed there were 3 nurses working that shift. On 7/20/20 on the 11:00 PM -7:00 AM shift the DNS indicated 4 NAs but the staffing sheet revealed there were only 3 NAs. The DNS sheet located in the notebook dated 9/11/20 was blank. Additional review of the notebook revealed the DNS sheet for 10/12/20 only contained the information for the 7:00 AM-3:00 PM shift. The 3:00 PM-11:00 PM shift information for staffing was blank. The 11:00 PM-7:00 AM shift information was also blank. The DNS sheet located in the facility notebook dated 2/26/21 revealed on the 7:00 AM -3:00 PM shift the staff working was documented as 2 Registered Nurses (RN), 3 Licensed Practical Nurses (LPN), 9 Nursing Assistants (NA) and 0 Medication Assistant (MA). A review of the assignment sheet dated 2/26/21 on 7:00 -3:00 PM shift revealed there were 1 treatment nurse, 1 nurse assigned to station 1, 1 nurse assigned to station 2 and a med-aide assigned to station 3 plus 8 NAs. The DNS indicated there were 4 NAs on the 3:00 PM - 11:00 PM. The assignment sheet revealed there were only 3 NAs on the 3:00 PM - 11:00 PM shift. Also, on the 11:00 PM -7:00 AM shift the DNS indicated there were 5 NAs but the assignment sheet indicated there were only 4 NAs.	F 732	Staffing Sheet with complete information to include facility name, date, census, total number and actual hours worked by the registered nurse, licensed practical nurse, and certified nurse aides. In-service will be completed by 4/12/21. All newly hired Administrator, Director of Nursing (DON), Scheduler, Receptionist and Nurse Supervisor will be in-serviced by the Staff Development Coordinator during orientation in regards to Posting of Daily Staffing Sheet. The Staff Development Coordinator will audit the Daily Staffing Sheets with daily assignment sheets to include weekends weekly x 4 weeks and monthly x 1 month to ensure daily posting includes complete and accurate information prior to the beginning of the shift utilizing the Daily Staffing Audit Tool. The Staff Development Coordinator and/or Scheduler will address all concerns identified during the audit to include re-training of staff. The Administrator will review and initial the Daily Staffing Audit Tool weekly x 4 weeks then monthly x 1 month for completion and to ensure all areas of concern were addressed. The Administrator will present the findings of the Daily Staffing Audit Tool to the Executive Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The Executive QAPI Committee will meet monthly for 2 months and review the Daily Staffing Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

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F 732	Continued From page 19 On 3/5/21 at 10:40 AM the Facility Scheduler (FS) stated she was responsible for the Daily Nursing Staffing sheets for more than 2 years. The FS observed the staffing sheets for 7/19/20 & 7/20/20 and indicated the information was not accurate because the DNS was not updated with the assignment when the assignment was updated. The FS observed the staffing sheet dated 9/11/20 was blank. She was not aware why the 9/11/20 DNS sheet was blank. The FS said the DNS sheet for 2/26/21 was not accurate because the information was not updated with the staffing changes when the changes were completed. She added one RN did not come to work so a NA was pulled to work in the MA position so the 7-3 shift should read 1 RN, 8 NAs and 1 Medication Assistant. The FS also reported the number of NAs on the 3-11 shift should read 3 instead of 4. The 11- 7 shift was also in error because there 4 NAs instead of the posted number of 5. The FS said she had corrected some of the DNS sheet and demonstrated her initials on DNS dated 9/15/20 where she made changes to that day. She was not able to provide an explanation for why the other DNS sheets were not corrected. On 3/5/21 at 11:35 AM the Director of Nursing stated each of the DNS sheets she reviewed were not accurate.	F 732	The Administrator and Director of Nursing are responsible for all audits, in-services and monitor for all plans of correction.	