STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345549	A. BUILDING _____ B. WING _____	C 03/08/2021

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UNIVERSAL HEALTH CARE / BRUNSWICK	1070 OLD OCEAN HIGHWAY BOLIVIA, NC 28422

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F 000	INITIAL COMMENTS An unannounced on cite complaint investigation was completed at this facility on 03/08/21. Event ID# PJW511. 3 out 13 allegations were substantiated resulting in deficiency.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to (1) accurately code the Minimum Data Set (MDS) assessment to reflect the activities of daily living and rejection of care for 1 of 6 resident's MDS assessments reviewed (Resident #3), and (2) failed to accurately code bilateral upper extremity impairment and tobacco use (Resident #1) for 1 of 6 residents reviewed for resident assessments. 1a. Resident #3 was admitted to the facility on 06/11/19 with diagnoses to include; diabetes, difficulty walking, obesity, oxygen dependent, congestive heart failure, chronic obstructive pulmonary disease (COPD), and the need for assistance with personal care. A review of the most recent Minimum Data Set (MDS) assessment dated 01/04/21 and coded as a quarterly assessment documented Resident #3 had intact cognition. She exhibited no behaviors and no rejection of care. She required extensive two-person assistance with bed mobility and toileting. The following activities of daily living	F 641	F641 Accuracy of Assessments 1. Resident #3 no longer resides in the community. Resident #1 Minimum Data Set (MDS) was corrected by the MDS nurse on 3/15/21 to reflect resident #1 bilateral upper extremity impairment and to reflect her tobacco use. 2. All residents are at risk of having their MDS not coded accurately. The MDS□s sections J1300 and G0400 completed in the past 2 weeks (starting 3/18/21) will be reviewed by the MDS nurse, Director of Nursing (DON) and/or Corporate MDS nurse for accuracy. Any inaccuracies found will be reported to the MDS nurse for correction. The MDS nurse will be educated on the steps needed to accurately code sections J1300 and G0400 of the MDS. The education was provided on 3/24/21 by the corporate MDS nurse consultant. 3. The case manager/MDS Coordinator will audit 5 resident MDS assessments to	3/26/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/24/2021

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F 641	Continued From page 1 were coded in Section G as "did not occur": eating, bathing, dressing, walk in room, and locomotion. The MDS assessment coded the following activities as "occurred once or twice": bed mobility, toilet use and hygiene. The resident was always incontinent of bowel and bladder. In an interview with the Travel MDS Nurse on 03/05/21 at 10:00 AM she stated she worked for the corporation helping several different facilities complete MDS assessments. She said she mostly worked remotely by reviewing aide and therapy documentation. She commented she was not in the facility when she assisted the MDS Nurse with this assessment for Resident #3. She recalled she knew this assessment was not correct and referred to her emails to explain she had sent a message to the MDS Nurse in the building explaining the assessment was not complete for Section G. She stated she expected the MDS Nurse who was in the building to continue gathering information through staff interviews and observations to accurately code the MDS assessment. She confirmed she had signed Section Z of the assessment as "complete" for Section G. In an interview with the MDS Nurse on 03/05/21 at 10:15 AM she stated she knew Resident #3 had received the care documented on the MDS assessment as "did not occur" and that the documentation within the assessment was incorrect. She recalled an email she had received from the Travel MDS Nurse telling her the assessment was not complete. She commented because the Travel MDS Nurse had signed off on Section G of the assessment, she assumed the section was complete and had not completed observations or staff interviews to	F 641	ensure coded correctly and supporting documentation for the lookback period per the RAI manual. Guidelines for review 5 residents per week for 4 weeks, then 5 residents twice monthly for 1 month, then 1 time a month for 1 month 4. Results of audits will be reviewed at the quarterly Quality Assurance meeting x1 for further problem resolution if needed	

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F 641	Continued From page 2	F 641		

correct the coding in Section G to accurately reflect the care Resident #3 had received during the assessment look back period.
1b. A phone interview was conducted on 03/05/21 at 11:22 AM with the MDS Nurse. She stated she was aware Resident #3 refused care. She stated she had a hard time moving around due to her weight and had shortness of breath and lung disease. She reported Resident #3 didn't want baths or showers and would refuse, and refused to get out of the bed when encouraged by staff. She stated refusal of care should have been documented on Resident #3's most recent quarterly assessment.

A phone interview was conducted on 03/05/21 at 2:15 PM with the Director of Nursing. She stated her expectation was for the MDS assessments to be coded accurately.

2a. Resident #1 was admitted to the facility on 09/13/17 with a readmit date of 01/25/21. Diagnoses included chronic leukocytosis (elevated white blood cell count due to Leukemia), anemia, coronary artery disease, heart failure, hypertension, chronic pain due to spondylosis, and history of falls.

A review of the Occupational Therapy and Plan of Treatment dated 01/08/21 revealed Resident #1 had an impairment to the Right Upper Extremity (RUE) and the Left Upper Extremity (LUE).

The Minimum Data Set (MDS) quarterly assessment dated 01/14/21 revealed the resident was cognitively aware. The resident required extensive assistance with two staff physical assistance with bed mobility, transfers, toileting and personal hygiene and extensive assistance

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F 641	Continued From page 3	F 641		

with one staff physical assistance with dressing. Resident #1 was coded as having an impairment to one side to upper extremity and both sides to lower extremity.

The MDS admission assessment dated 02/01/21 revealed the resident was cognitively aware. The resident required extensive assistance with two staff physical assistance with bed mobility, transfers, toileting and personal hygiene and extensive assistance with one staff physical assistance with dressing. Resident #1 was coded as having an impairment to one side to upper extremity and both sides to lower extremity.

An observation of Resident #1 on 03/01/21 at 4:20 PM revealed the resident had contractures to the right upper extremity and the left upper extremity.

An interview with the MDS Nurse on 03/03/21 at 4:25 PM revealed she obtained her assessment data by assessing the resident, reviewing physician orders, reviewing progress notes, reviewing the medication administration record and the treatment administration record and by reviewing notes from the therapy disciplines including Physical Therapy, Occupational Therapy, and Speech Therapy. The MDS nurse reviewed the Occupational Therapy notes during this interview and reported the Occupational Therapist documented Resident #1 had impairments to the RUE and LUE and she must have missed that when she was completing the assessments.

2b. The MDS quarterly assessment dated 01/14/21 revealed the resident was cognitively aware. The MDS indicated the resident did not

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F 641	Continued From page 4	F 641		

use tobacco with a "no" answer.

The MDS admission assessment dated 02/01/21 revealed the resident was cognitively aware. The MDS indicated the resident did not use tobacco with a "no" answer.

A review of Resident #1 ' s care plan updated on 02/02/121 revealed the resident used snuff with potential for spillage and dirty/hands and face. The appropriate goals and interventions were in place.

An interview with Resident #1 on 03/01/21 at 4:20 PM revealed she had been using snuff for a long time, but she could not recall when she started. The Resident stated she had no complications from using snuff.

An interview was conducted with the MDS Nurse on 03/02/21 at 12:20 PM. The MDS nurse stated she was not sure that snuff was documented as tobacco product in the MDS assessments.

An interview with the MDS Nurse on 03/02/21 at 12:35 PM revealed she reviewed the MDS information and stated snuff should be recorded as a tobacco product.

An interview was conducted with the MDS Nurse on 03/03/21 at 4:25 PM. The MDS Nurse stated the resident has been using snuff for a long time and the MDS assessments should have been marked "yes" for tobacco use.

An interview was conducted with the Director of Nursing (DON) via phone on 03/08/21 at 2:30 PM. The DON reported her expectation of the MDS Nursing staff was to ensure they were

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F 641	Continued From page 5 completing the MDS assessments accurately to reflect the current care that needs to be provided for the residents.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document	F 656		3/26/21

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F 656	Continued From page 6 whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and resident interviews, the facility failed to implement an intervention that was put in place in a care plan for fall prevention for 1 of 4 residents ' (Resident #1) care plans reviewed. Findings included: Resident #1 was admitted to the facility on 09/13/17 with a readmit date of 01/25/21. Diagnoses included chronic leukocytosis (elevated white blood cell count due to Leukemia), anemia, coronary artery disease, heart failure, hypertension, chronic pain due to spondylosis, and history of falls. The Minimum Data Set dated 02/01/21 revealed the resident was cognitively aware. Resident #1 demonstrated no moods or behaviors such as refusing care. The resident required extensive assistance with two staff physical assistance with bed mobility, transfers, toileting and personal hygiene and extensive assistance with one staff physical assistance with dressing. Resident #1 was not coded as having any falls during this assessment. A nursing note written by Nurse #1 on 02/28/21 revealed while providing incontinence care, staff	F 656	F656 Develop/Implement Comprehensive Care Plan 1. Resident #1 continues to reside in the community. The resident□s care plan and care guide used by the nursing assistants (NAs) were updated to reflect that 2 people were required to provide care for the resident. 2. All residents requiring assistance with care, while in bed, are at risk of falling. Care plans and care guides for all residents assessed as a high risk of falls will be reviewed by the Director of Nursing (DON), Unit Manager (UM) and/or the Minimum Data Set (MDS) nurse to assure interventions to help prevent falls were in place and followed by staff. Nursing Assistant (NA) #4 will be given 1:1 education by the DON in where to find care information and the expectation to follow that information. The education with NA #4 will be completed by 3/19/21. All licensed nursing staff and unlicensed nursing staff will be educated by the DON and or unit manager. The education will consist of instructing staff where to find care information and the expectation that	

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F 656	Continued From page 7	F 656		

had resident rolled onto left side in the bed (bed was elevated for care to 2.5 feet off floor.) During this time, staff reached for a brief with one hand on the resident ' s hip and the resident tipped on forward and rolled off the bed on the left side of the bed. Vital signs were stable. There was a skin tear measuring 3.5 cm X 0.2 cm noted to right elbow which was cleansed with normal saline and covered with Vaseline gauze and dressing. The resident was assisted off the floor with 4 staff assist and a mechanical lift. The Director of Nursing, responsible party and the on-call clinician were notified. The staff were instructed to provide incontinence care with 2 staff members: with one on each side of the bed.

Resident #1 ' s updated care plan dated 03/02/21 revealed a plan of care for at risk for falls. The interventions included, in part, two personnel to provide care at bedside.

An interview was conducted with Nursing Assistant (NA) #4 via phone on 03/03/21 at 5:45 AM. NA #4 stated she was providing care for Resident #1 on the night she rolled off the bed on 02/28/21 going into 03/01/21. NA #4 stated she cared for Resident #1 during this night shift on 03/03/21 and performed care by herself. NA #4 stated the resident was not that hard to do care for with one person. NA #4 stated as a result of the fall, the resident sustained a bruise to her rib and a skin tear. NA #4 stated the intervention that was put in place was to have two people at the bedside doing care with one person on each side. NA #4 confirmed she should have asked for help when doing bedside care on Resident #1 during this shift on 03/03/21.

An interview was conducted with Resident #1 on

care planned interventions will be followed. Staff will be informed that failure to follow the care planned interventions will result in disciplinary action, up to and including, termination. Education for staff will be completed by 3/26/21.

3. The DON, Unit Manager (UM) and other administrative staff will randomly observe individual rooms during morning rounds (Monday through Friday) to assure fall interventions (2 person assist, fall mats, low beds, non-skin socks, etc.) are in place and used as care planned. Any intervention that is observed not being used will be reported to the DON for required action. Immediate re-education will be provided to the staff member not utilizing care planned fall prevention interventions. The DON and/or the UM will enter the community during evening and/or night shift and observe care rendered to assure compliance with following the care planned fall prevention interventions. This will continue 1 off hour entry per week x 4 weeks, 1 off hour entry every 2 weeks for 4 weeks and then an off-hour entry monthly thereafter until substantial appliance has been achieved. Staff observed not utilizing fall prevention interventions will be re-educated and receive disciplinary action up to and including termination. Information about where to find fall prevention interventions will be included in the orientation process for nurses and nursing assistants.

4. Results of the audits will be presented to the Quality Improvement Performance Improvement Committee monthly by the DON until compliance has been achieved

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F 656	Continued From page 8 03/03/21 at 9:45 AM. Resident #1 reported that two staff members had changed her a couple of hours ago. Resident #1 was asked if two staff members assisted her during the night shift last night and she stated "no, only one." Resident #1 stated she had fallen off her bed and that was why two people were supposed to help her when she was getting changed. An interview was conducted with the Director of Nursing (DON) via phone on 03/08/21 at 2:30 PM. The DON stated her expectation of the nursing staff was to follow the Resident ' s care plan and to ensure there were two staff whenever providing bedside care for Resident #1 to prevent further falls.	F 656	and maintained.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and resident interviews, the facility failed to follow the physician orders for wound prevention for 1 of 2 residents (Resident #1) observed for pressure ulcers. Findings included:	F 684	F684 Quality of Care 1. Resident #1 remains in the community. On 3/17/21, a therapy referral was submitted for pressure ulcer prevention recommendations by the Director of Nursing (DON). 2. All residents are at risk of pressure	3/26/21

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F 684	Continued From page 9 Resident #1 was admitted to the facility on 09/13/17 with a readmit date of 01/25/21. Diagnoses included chronic leukocytosis (elevated white blood cell count due to Leukemia), anemia, coronary artery disease, heart failure, hypertension, chronic pain due to spondylosis, and history of falls. The Minimum Data Set (MDS) dated 02/01/21 revealed the resident was cognitively aware. Resident #1 demonstrated no moods or behaviors such as refusing care. The MDS indicated Resident #1 had two Stage 1 pressure ulcers with a pressure reducing device in bed and required pressure ulcer care. A physician ' s order written on 01/25/21 revealed an order to offload heels at all times. A physician ' s order written on 01/28/21 revealed an order to apply protective dressing to bilateral heels every 3 days. A review of the care plan last updated on 03/01/21 revealed a plan of care goal which included wounds would display positive healing by next review. The intervention included: treatments as ordered to wounds, monitor for non-healing or infection. A review of the Treatment Administration Record revealed the protective dressing to the bilateral heels was last done on 02/27/21 as evidenced by nursing initials and a check mark. According to the order, the next treatment date would have been 03/03/21. A review of the Medication Administration Record (MAR) revealed a treatment to offload heels at all times. The MAR indicated the heels should be	F 684	ulcer prevention interventions not utilized by staff. An audit was conducted by the Regional Clinical Consultant on 3/16/2021, of all treatment records, to identify pressure ulcer prevention interventions. Rounds were completed on 3/16/21 to observe if those interventions were in place. Results of rounds were presented verbally to the DON and the Administrator on 3/16/21. 3. The DON, Therapy Manager, Unit Manager and/or Weekend Supervisor will educate all nursing staff on how to effectively float heels to relieve pressure, use pillows for positioning and utilize specialty boots for off-loading pressure from residents heels per physician s orders. This education will be completed by 3/26/21. Education will be presented to Community Department Managers on 3/18/21 by the Regional Clinical Consultant, DON and/or Therapy Manager on floating heels, specialty boots and turning and positioning to reduce the risk of pressure ulcers. Each manager will be educated on the expectation that during Ambassador Rounds (rounds in which each department manager observes and speaks to a set of assigned residents) they observe to make sure pressure ulcer prevention interventions are in place and properly utilized. Observations by administrative staff will be conducted Monday through Friday and results of the observations will be logged onto Ambassador Rounds sheets. On weekends, the Weekend Supervisor will round to observe for utilization of pressure ulcer reduction interventions. Education	

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F 684	Continued From page 10 checked at 2:30 PM and 10:30 PM. A review of the March MAR revealed the residents ' heel were offloaded at 2:30 PM and 10:30 PM as evidenced by a check mark and the nurse ' s initials. An observation of Resident #1 on 03/01/21 at 4:20 PM revealed the resident was lying in bed. The resident was noted to have both legs lying flat on her bed. The resident ' s bilateral (both) feet were wrapped with a dressing and the date on the dressing read: 02/27/21. The heels were not off loaded. An observation of Resident #1 on 03/02/21 at 10:00 AM revealed the resident was lying in bed. The resident was noted to have both legs lying flat on her bed. A pillow was noted to be under her calves, but the heels were not off loaded. Resident #1 had both feet wrapped with a dressing and the date on the dressing read: 02/27/21. An observation of incontinent care was done with Nursing Assistant (NA) #1 and NA #5 at 1:30 PM on 03/02/21. The Resident was informed by NA #1 she would be doing incontinent care and was provided privacy. When NA #1 and NA #5 removed the bed covers from Resident #1, the resident was noted to have a pillow under her calves, but her feet were not off loaded. The dressing to her feet was intact and dated 02/27/21. NA #1 and NA #5 completed the incontinent care, repositioned the resident to lift her higher up on the bed and put the pillow under her calves, but the feet were not offloaded. They applied bed covers on to the resident, lowered the bed, and provided the call bell.	F 684	on pressure ulcer prevention interventions will be included in nurse and nursing assistant orientation starting immediately. The results of the audits will be logged onto weekend round forms. The audits (rounds) will continue 7 x per week for 4 weeks, then 3x per week x 4 weeks, then weekly x 4 weeks. 4. Results of the audits will be presented to the Quality Improvement/Performance Improvement Committee by the DON monthly x 3 or until compliance is achieved and maintained	

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An interview was conducted with NA #1 on 03/02/21 at 1:42 PM. NA #1 stated she put the pillow under the resident ' s calves because the nurse told her too, and she did not know why the resident had dressings to her feet. NA #1 reported Resident #1 stayed in bed a majority of the time. NA #1 stated since she came back from the hospice house in January, Resident #1 has not gotten out of bed.

An observation of Resident #1 on 03/02/21 at 5:30 PM revealed the resident was lying in bed. The resident was noted to have both legs lying flat on her bed. A pillow was noted to be under her calves, but the heels were not off loaded. Resident #1 had both feet wrapped with a dressing and the date on the dressing read: 02/27/21.

An interview was conducted with Resident #1 on 03/02/21 at 5:30 PM. Resident #1 reported she did not know why her feet had a dressing applied to them and she did not know that her heels should be off the bed. Resident #1 stated she does not get out of bed.

An observation of Resident #1 on 03/03/21 at 2:50 PM revealed the resident was lying in bed. The resident was noted to have both legs lying flat on her bed. A pillow was noted to be under her calves, but the heels were not off loaded. Resident # 1 had both feet wrapped with a dressing and the date on the dressing read: 02/27/21.

An interview was conducted with Nurse #2 on 03/03/21 at 4:10 PM. Nurse #2 reported the resident did not get out of bed and added she was "bed bound and on hospice." Nurse #2

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	345549	A. BUILDING _____ B. WING _____	C 03/08/2021

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stated the nurses were required to do the wound care treatment on the residents since they no longer had a wound treatment nurse. Nurse #2 stated she had not changed Resident #1 ' s dressings to her bilateral feet today. Nurse #2 reviewed the order and stated that the bilateral heel dressings should have been changed on 03/02/21. Nurse #2 stated she did not know why they were not changed on 03/02/21.

An observation of the wound prevention treatment was conducted on 03/03/21 at 4:20 PM with Nurse #2. The Resident was informed by Nurse #2 she would be changing the dressings to her heels. Nurse #2 removed the bed covers from the lower part of Resident #1 ' s body. A pillow was noted to be under the resident ' s calves and her bilateral feet were lying flat on the bed. Nurse #2 proceeded to remove the bandage from the right heel. The right heel bandage was noted to have a date on the dressing of 02/27/21. Nurse #2 stated the date on the dressing indicated the last time the dressing was changed. The heel was noted to be intact. There was no dryness, but it was noted to be reddened. Nurse #2 proceeded to remove the bandage from the left heel. The left heel dressing was noted to have a date on the dressing of 02/27/21. The left heel was noted to be intact. There was no dryness noted, but the left heel was noted to be more reddened than the right heel. A dressing was reapplied to both heels and dated with 03/03/21. During this observation, Nurse #2 confirmed the resident ' s heels were not offloaded and should have been to prevent skin breakdown to her heels. Nurse #2 placed two pillows under the resident ' s calves and ensured the heels were off loaded at this time.

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F 684	Continued From page 13 An interview was conducted with the Director of Nursing (DON) on 03/08/21 at 2:30 PM via phone. The DON reported her expectation of the nursing staff was to follow the physician orders as written. The DON stated the resident was bed bound and her heels should be offloaded at all times to prevent any skin breakdown, and the dressings should have been changed, as ordered, so that the nurse could reassess the heels to ensure there was no skin breakdown.	F 684		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and resident interviews, the facility failed to implement	F 692	F692 Nutrition/Hydration Status Maintenance	3/26/21

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F 692	Continued From page 14 a dietary recommendation for ice cream to be served with the lunch and dinner meals for 1 of 1 residents (Resident #1) observed for dietary needs. Findings included: Resident #1 was admitted to the facility on 09/13/17 with a readmit date of 01/25/21. Diagnoses included chronic leukocytosis (elevated white blood cell count due to Leukemia), anemia, coronary artery disease, heart failure, hypertension, chronic pain due to spondylosis, and history of falls. The Minimum Data Set dated 02/01/21 revealed the resident was cognitively aware. Resident #1 demonstrated no moods or behaviors such as refusing care. The resident required limited assistance with one staff physical assistance with eating. Resident was coded as being on hospice. A review of Resident #1 ' s care plan updated on 02/15/21 revealed the resident had a plan of care in place for Nutrition for at risk for weight loss and dehydration related to diagnoses with interventions to include, in part, refer to dietician for evaluation of current nutritional status as indicated, assess resident food preferences, offer food alternatives when appropriate for any meal, and refer to speech therapy for swallowing evaluation as needed. A review of a Registered Dietician (RD) note written on 02/08/21 revealed, in part, a recommendation to add ice cream to lunch and dinner. The February and March 2021 Medication	F 692	1. Resident #1 continues to reside in the community. Orders for ice cream to be served at lunch and dinner were verified. The dietary department received the dietary meal slip on 3/19/21. 2. All residents receiving supplements at meals are at risk of not receiving the supplements as ordered. The Dietary Manager (DM) and Kitchen Manager were in-serviced by the Regional Clinical Consultant on 3/17/21 regarding the importance of including supplements as ordered on residents trays to halt or prevent weight loss. The Dietary Manager in-serviced dietary staff on the importance of including supplements as ordered on residents trays on 3/6/21. A list of residents receiving dietary supplements will be prominently displayed in the meal preparation area and be readily available to staff preparing meal trays. Nurses and Nursing Assistants (NAs) will be educated by the Director of Nursing (DON), DM and/or the unit manager to compare the tray card to the tray delivered to the resident. If the supplement is missing, the nursing staff will be educated to notify the dietary staff and dietary staff will deliver the supplement. 3. The Dietary Manager and Kitchen Manager will audit tray cards against physician s orders to assure all ordered supplements are included on the tray cards. This will be completed by Friday, March 22, 2021. Beginning on Thursday, March 18, 2021, the Dietary Manager and/or the Kitchen Manager will audit all meal trays before they leave the dietary department to assure all supplements	

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F 692	Continued From page 15 Administration Record and Treatment Administration Record were reviewed and revealed there was no order to add ice cream to the lunch and or dinner tray daily. A dietary ticket was provided for Resident #1 on 03/02/21 at 8:00 AM. The dietary ticket revealed the resident had non applicable (N/A) under allergies and N/A for likes and dislikes for breakfast, lunch, and dinner. Under the "Notes" section for lunch and dinner the dietary ticket stated "no chicken, send hamburgers with mayo on bun and cut all sandwiches into quarters." An interview was conducted with the Dietary Manager (DM) on 03/02/21 at 8:00 AM. The DM stated he had spoken to the resident, and as of two weeks ago, she had changed her mind about food she likes and doesn ' t like. The DM stated he paid close attention to this resident because she was particular about her food. An observation of Resident #1 on 03/02/21 at 1:08 PM revealed the resident did not have ice cream on her lunch meal tray. An interview was conducted with Resident #1 on 03/02/21 at 1:08 PM and she stated she never received ice cream on her lunch or dinner meal trays. An interview with the Registered Dietician (RD) on 03/04/21 at 12:21 PM via phone revealed the RD stated the resident had previously had wounds and had a weight loss. The RD stated she was recently readmitted from hospice and she recommended adding ice cream for extra calories and protein and a pleasure food. The RD stated she sent the recommendation to the	F 692	have been included as ordered. The meal tray audit will continue daily x 2 weeks, then 3 times a week x 4 weeks, then weekly x 4 weeks. Results of the audit will be recorded on a supplement log. Any tray found to not include the ordered supplements will have the supplement added prior to leaving the kitchen area. The employee responsible for not adding the ordered supplement will be re-educated. Employees that continually fail to add the ordered supplement will receive disciplinary action which may include termination. 4. Results of the dietary supplement audit will be presented to the Quality Improvement/Performance Improvement committee monthly by the Dietary Manager. The is continue until substantial compliance is achieved and sustained.	

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Director of Nursing (DON) and to the Dietary Manager. The RD stated the DON would put the orders in the system and let the kitchen staff know and the kitchen staff would provide the recommendation and update the dietary ticket. The RD stated if it was ice cream or Med Pass (a nutrition supplement), she believed the order had to be put into the system to process it.

An interview was conducted with the Dietary Manager (DM) on 03/04/21 at 1:15 PM via phone. The DM reported for breakfast the resident liked oatmeal, boiled eggs and a juice and coffee. The DM stated for lunch and dinner the "note" section stated we were to give her no chicken and if she had a hamburger on a bun, we were to cut it in four quarters. The DM stated her dietary ticket stated there were no dislikes and no likes. The DM reported there were no other items listed on the note section of the dietary ticket. The DM stated if she were to get ice cream on her lunch and dinner tray, he would indicate that under the notes section. The DM initially reported, during the interview, there was no ice cream listed on the lunch or dinner tray, and then, during the interview, he added that the ice cream was listed on the dietary ticket under notes, but he did not know why it did not indicate to give ice cream on the lunch and dinner tray on the 03/02/21 dietary ticket that was provided for review.

An interview with the Director of Nursing (DON) via phone on 03/08/21 at 2:30 PM revealed her expectation of the staff was to ensure the dietary recommendations were implemented and followed. The DON added the resident was at risk for skin breakdown since she was bed ridden and with the decreased oral intake, the ice cream would help by adding the extra calories and

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F 692	Continued From page 17 protein she needed.	F 692		
F 727 SS=D	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to use the services of a registered nurse (RN) for at least 8 consecutive hours a day, 7 days a week for 14 of 90 days reviewed for staffing. Review of the facility Report of Nursing Staff Directly Responsible for Resident Care documentation for December 2020, January 2021 and February 2021 revealed the facility did not use the service of a registered nurse on the following dates: 12/06/20, 12/12/20, 12/19/20, 12/20/20, 12/25/20, 12/26/20, 12/27/20, 01/01/21, 01/03/21, 01/09/21, 02/06/20, 02/07/21, 02/20/21, and 02/21/21. In an interview conducted with the facility Administrator on 03/02/21 at 7:15 AM he stated	F 727	F727 RN 8 hours/7days/wk., Full Time DON 1. During the survey, ending on 3/8/21, it was found the community did not have RN coverage for a continuous 8 hours per day, 7 days a week on multiple days. 2. There continues to be a risk of not having an RN assigned for 8 continuous hours per day, 7 days per week. The community will make every effort to provide RN coverage 8 hours per day, 7 days per week. 3. The community continues to recruit a RN on Indeed.com as well as offering a sign on bonus for a RN and increased the pay scale to compete with local industry. RN recruitment posters will be placed at the local community college.	3/26/21

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F 727	Continued From page 18 there had been 14 days in the past 3 months when the facility had not had RN coverage in the building. He explained the reason for the staffing shortage was the lack of applicants. He said except for 12/25/20 all the days the building did not have RN coverage fell on weekends. He commented the facility had began to offer a sign on bonus and increased the pay scale in every category for RN's. They had also began to advertise. He reported two RN's were currently in the interview process. In an interview with the Director of Nursing on 03/02/21 at 11:05 AM she stated she expected there to be an RN in the building for at least 8 hours, 7 days a week.	F 727	Advertisements, for RN recruitment, will also be posted in the local newspaper. On 3/12/2021, an RN who will function as Assistant Director of Nursing was hired. On 3/11/21 a RN weekend supervisor was hired. 4. Each month the Administrator will report to the Quality Improvement/Performance Improvement Committee any new RN employees and efforts to recruit RN candidates	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F 842		3/26/21

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F 842	Continued From page 19 §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening	F 842		

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F 842	Continued From page 20 and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to document the provision of baths and showers, and the refusal of baths and showers for a resident who had a self-care deficit for 1 of 1 resident (Resident #3) reviewed for ADL (activities of daily living) care. Findings included: Resident #3 was admitted to the facility on 06/11/19 with diagnoses to include in part; diabetes, difficulty walking, obesity, oxygen dependent, congestive heart failure, chronic obstructive pulmonary disease (COPD), and the need for assistance with personal care. A review of the most recent Minimum Data Set (MDS) dated 01/04/21 documented Resident #3 was cognitively intact. She exhibited no behaviors and no rejection of care. She required extensive two-person assistance with bed mobility and toileting. Transfers did not occur during the assessment period. Hygiene activity only occurred once or twice with two-person assistance. Bathing did not occur, and/or facility staff provided 100% care. She had bilateral upper extremity impairment, and impairment on one side of her lower extremity. She required a wheelchair for mobility and was incontinent of bowel and bladder.	F 842	F842 Resident Records-Identifiable Information 1. Resident #3 no longer resides in the community. 2. All residents that require assistance with daily care are at risk of not receiving showers and/or baths. Nursing assistants (NAs) will be educated by the Director of Nursing (DON) and/or the Unit Manager (UM). Education will include how to document a shower, bath or refusal of a shower/bath in the kiosk and the expectation that documentation be completed before the end of the shift. Education will also include instructing the NA to notify the primary care nurse if a resident refuses the bath and/or shower. Nurses will be educated by the DON and/or UM to document any reported refusals of care and to notify the care plan nurse so refusal of care or preference for a bed bath may be included on the resident□s individualized care plan. The nurses□ education will include checking NA documentation near the end of the shift to assure all NAs have documented care and if documentation is not present, to inform the NA that documentation is required before the end of the shift. Any NA not completing required	

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F 842	Continued From page 21 A care plan revised 09/23/20 revealed Resident #3 had a self-care deficit and required staff assistance for all ADL's. The goal of care was to increase independence with ADL's by the next review. Interventions included; the Occupational Therapist would work with the resident on transfers and ambulation, and with ADL re-training. Additional interventions included; to give verbal clues to prompt resident, to break up tasks into smaller steps, allow rest breaks, and provide assistance with bathing. A review of the progress notes from 10/01/20 through 01/24/21 revealed no documentation of refusal of ADL care. A review of the Bath Report Roster from 11/01/20 through 01/31/21 revealed Resident #3 received a complete bed bath on 11/23/20, 11/25/20, and 12/02/20, and received a shower on 12/23/20 and 01/23/21. On 01/24/21 at 12:06 AM it was documented that Resident #3 received no bath that day. There was no documentation on the Bath Report to support that Resident #3 received a bath, a shower, or refused care on any other days from 11/01/20 through 01/24/21. A review of the ADL Assistance and Support Log from 12/01/20 through 12/31/20 for bathing revealed on 12/07/20, 12/17/20, and 12/22/20 the activity did not occur. On 12/24/20 it was documented Resident #3 was total dependent with bathing and received physical help in part with bathing. All other dates during December 2020 were left blank. A review of the ADL Assistance and Support Log from 01/01/21 through 01/31/21 for bathing revealed on 01/06/21 it was documented that	F 842	documentation will receive re-education and disciplinary action up to and including termination. Nurses not checking NA documentation prior to the end of the shift and requiring NA completion will receive re-education and disciplinary action up to and including termination. Education will be completed by Friday, March 26, 2021. Education for documentation of refusal of care will be included in orientation for nurses and nursing assistants 3. Beginning on 3/19/21, the DON, weekend supervisor and/or the UM will audit the bath book daily to assure all residents are receiving their bath as scheduled. Completion of showers/baths as scheduled will be documented on a shower/bath log. Those residents that consistently refuse showers and/or baths will receive a revision of their care plan by the assessment nurse. Beginning on 3/23/21, the staff nurses will be required to check the NA documentation prior to the end of the shift and if documentation is missing to notify the specific NA. Nurse□s notes will be reviewed by the DON daily Monday through Friday for any notation of resident refusal of bath and/or shower. The Social Worker (SW) will interview 5 alert and oriented residents per week x 4 weeks, then every other week x 4 weeks, then monthly x 1 month to determine if the resident is receiving showers and/or baths per schedule. A report will be given to the DON if any resident states showers/baths are not being received as scheduled. The SW will keep a log of residents interviewed, the date of interview and the residents□	

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UNIVERSAL HEALTH CARE / BRUNSWICK	1070 OLD OCEAN HIGHWAY BOLIVIA, NC 28422

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F 842	Continued From page 22 Resident #3 was total dependent with bathing and received physical help in part with bathing. On 01/07/21, 01/13/21, and 01/22/21 it was documented the activity did not occur. All other dates during January 2021 were left blank. Resident #3 was hospitalized 01/16/21 through 01/22/21, returned to the facility on 01/22/21 and readmitted to the hospital on 01/23/21. Resident #3 did not return to the facility. An interview was conducted with Nurse #3 on 03/02/21 at 11:45 AM. She stated Resident #3 was alert and oriented and could make her needs known to staff. She required total care and was incontinent of bowel and bladder. She reported Resident #3 refused to take showers, and at one-point staff were getting her up to her wheelchair then she decided she didn't want to get out of bed anymore. The nurse reported she was compliant with medications and treatments but was not compliant with getting out of bed or going down for baths or showers. She stated she was not sure why Resident #3 would refuse her bed baths. Nurse #3 reported the nurse aides should have documented baths and showers, and should notify the nurse of refusals. She stated refusals would be documented in the resident's progress notes. An interview was conducted on 03/02/21 at 12:19 PM with Nurse Aide #1. She stated Resident #3 required total care and was not compliant with care. She stated Resident #3 would stay in bed for long periods of time and refused to get up and thought she feared the mechanical lift. She reported Resident #3 had no desire to get out of bed, but she would let her give her a bath or wipe her down, and never refused her baths when she	F 842	comments. Education on the expectation of bath/shower completion, documentation of completed bath/shower and documentation of refusal of bath and/or shower will be integrated into the orientation process for nurses and nursing assistants. 4. The DON will present the results of the audits to the Quality Improvement/Performance Improvement committee monthly until substantial compliance is achieved and sustained.	

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F 842	Continued From page 23	F 842		

was assigned to her. She stated she went to the whirlpool bath on two occasions but usually refused to get on the gurney for showers because she was fearful. She indicated baths and showers would be documented in the Kiosk, and she would notify the nurse if the resident refused.

An interview was conducted on 03/02/21 at 1:58 PM with the wound treatment nurse. She reported Resident #3 was not compliant with care and was very particular on who she would allow to get her up for baths because she was afraid of the Hoyer lift and didn't have confidence in staff, so she would most likely refuse care for some staff. She stated the nurse aides documented baths and showers, and the nurses were supposed to document refusals in the progress notes.

During an interview on 03/03/21 at 9:11 AM, Nurse Aide #5 stated baths and showers were documented in the Kiosk and she would notify the nurse if a resident refused care including baths or showers. She reported she could only verbally notify the nurse of refusals because there was no place in the Kiosk that allowed staff to document refusals of care.

During an interview with the Director of Nursing (DON) on 03/03/21 at 5:50 PM, she stated Adult Protective Services came to the facility around 02/01/21 and that was when the problem with documentation of Resident #3's baths and showers was identified. She stated bath sheets were implemented and the nurse aides were notified verbally where to document baths and showers and in serviced on using the bath sheets. The DON reported an in-service was conducted on 02/09/21 and 02/10/21 regarding bath sheet documentation after it was discovered

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F 842	Continued From page 24 that documentation still wasn't getting done. She stated another in-service was conducted on 03/02/21 because staff lacked knowledge on where and how to document refusals. She reported she had not audited the bath book and stated Nurse Aide #3 would audit the bath book weekly moving forward. During an interview on 03/04/21 at 2:26 PM, Nurse #7 stated she worked with Resident #3 many times. She stated staff offered the shower many times and she didn't want it. She reported she had an oversized wheelchair in her room, and she would encourage her to get in the wheelchair to get out of the room, but she always refused to get out of bed, and would flat out refuse baths and showers most days. Nurse #7 indicated refusals should be documented in the medical record. A phone interview was conducted on 03/05/21 at 11:22 AM with the MDS Nurse. She stated Resident #3 had a hard time moving around due to her weight and had shortness of breath and lung disease. She reported she refused baths or showers, and refused to get out of the bed when encouraged by staff. She reported refusal of care should have been documented in the medical record and on the most recent MDS assessment. A phone interview was conducted on 03/05/21 at 2:15 PM with the DON. She stated the nurse aides were expected to document baths and showers, and notify the nurse if the resident refused care.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		3/26/21

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F 880	Continued From page 25 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be 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,	F 880		

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F 880	Continued From page 26 depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff interviews, and a review of the facility's policy and procedures, staff failed to implement the facility guidelines regarding use of personal protective equipment (PPE) during COVID-19 when two staff members did not wear the full PPE required (Nurse #3 and Personal Care Aide #1) while providing care in the resident's room and when assisting a resident back to their room after taking the quarantine resident to the shower room for 2 of 2 residents who were on Enhanced Droplet Precautions (Resident #5 and Resident	F 880	F880 Infection Prevention and Control 1. Nurse #3 and Personal Care Attendant (PCA) #1 were in-serviced by the Director of Nursing (DON) on 3/2/21 regarding using personal protective equipment (PPE) in all rooms displaying Enhanced Droplet Precaution signage. 2. All staff are at risk of entering rooms without the proper PPE. All staff (dietary, housekeeping, nursing and maintenance)	

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F 880	Continued From page 27 #6). This failure occurred during the COVID-19 pandemic. Findings included: The facility's COVID-19 Response Guidelines Policy revised on 02/03/21 included; personal protective equipment (PPE) was used every day by healthcare personnel (HCP) to protect themselves, residents, and others when providing care. PPE helps protect HCP from many hazards encountered in healthcare facilities. Staff will use appropriate PPE when they are interacting with residents, to the extent PPE is available and per CDC (Centers for Disease Control and Prevention) guidance on conservation of PPE. 1. During an observation on 03/02/21 at 4:30 PM, PPE was observed in the supply cart outside of Residents #5's room. The PPE cart included masks, gloves, and gowns. An Enhanced Droplet Precaution sign was posted on Resident # 5's door which provided instructions to perform hand hygiene and don full PPE to include a mask, eye protection, gown, and gloves before entering the room. During an observation on 03/02/21 at 4:30 PM, Nurse #3 was observed in Resident #5's room administering a medication. Nurse #3 was wearing a mask and eye protection and was not wearing gloves, or a gown. During an interview on 03/02/21 at 4:35 PM, Nurse #3 acknowledged Resident #5 was on enhanced droplet precautions due to being recently admitted from the hospital. She stated she just didn't don full PPE before going in the room to administer the medication and stated she	F 880	are to be educated on when to wear PPE, what PPE to wear, how to don and doff PPE and how to dispose of PPE beginning on 3/18/21. Education will also include assuring to the best ability that all residents wear masks when out of their individual rooms. The education will be completed by 3/25/21. Education will be given by the Regional Clinical Consultant, Director of Nursing (DON) and/or the Administrator. 3. Random audits will be conducted daily x 14 days by the DON, Administrative Staff, weekend supervisor and/or the Administrator. These observations will include all shifts and all departments. Documentation will include who was observed and if they did or did not comply with precautions related to Enhanced Droplet precautions. Immediate re-education will occur with any breach of enhanced droplet precaution protocol. Continued disregard for Enhanced droplet precaution protocol will result in disciplinary action up to and including termination. Education on infection control practices will be integrated into orientation for all community employees. 4. Results of the infection control audit will be presented monthly to the Quality Improvement/Performance Improvement committee until substantial compliance is achieved and sustained.	

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F 880	Continued From page 28	F 880		

should have donned gloves and a gown prior to entering the room.

An interview was conducted on 03/02/21 at 5:00 PM with the Director of Nursing. The DON stated staff were required to follow the facility guidelines for PPE use and full PPE should be worn when entering a resident's room who was on enhanced droplet precautions.

2. During an observation on 03/02/21 at 10:25 AM, PPE was observed in the supply cart outside of Resident #6 ' s room. The PPE cart included masks, gloves, and gowns. An Enhanced Droplet Precaution sign was posted on Resident #6 ' s door which provided instructions to perform hand hygiene and apply full PPE to include a mask, eye protection, gown, and gloves before entering the room.

During an observation on 03/02/21 at 10:25 AM, Personal Care Assistant #1 (PCA) was observed transferring Resident #6 from the hall to Resident #6 ' s room via her wheelchair. PCA #1 was noted to be wearing a mask and eye protection. Resident #6 also had a mask on. PCA #1 was observed entering Resident #6 ' s room with the resident without applying a gown or gloves.

During an interview with PCA #1 on 03/02/21 at 10:35 AM, PCA #1 confirmed the resident ' s door was noted to have an Enhanced Droplet Precaution sign on it. PCA #1 stated she thought the resident was no longer on precautions and that was why she entered without applying the gown or gloves. The PCA stated Resident #6 was brought out of her room to the shower room because she was asked by Nursing Assistant (NA) #1 to give the resident a shower. PCA #1 stated if Resident #6 was still on precautions and

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F 880	Continued From page 29	F 880		

quarantined, she should not have brought her out of her room to be showered.

An interview was conducted with the Medical Records Personnel (MPR) on 03/02/21 at 10:38 AM. The MRP was working at the nurse ' s station and she stated the resident was still on precautions and that was why the sign was on the door. The MRP stated the resident should remain quarantined to her room until 03/03/21.

An interview was conducted with NA #1 on 03/02/21 at 10:50 AM. NA #1 confirmed she asked PCA #1 to give Resident #6 a shower. NA #1 stated she saw the sign for the PPE on the door but stated "for some reason I thought she was off precautions." NA #1 stated she should not have asked PCA #1 to give the resident a shower outside of her room since she was on quarantine and had a precaution sign on her door.

An interview was conducted on 03/02/21 at 5:00 PM with the Director of Nursing (DON). The DON stated staff were required to follow the facility guidelines for PPE use and full PPE should be worn when entering a resident ' s room who was on Enhanced Droplet Precautions.