STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345011	A. BUILDING _____ B. WING _____	C 03/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT LEXINGTON	279 BRIAN CENTER DRIVE LEXINGTON, NC 27292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Recertification Survey was conducted 3/7/2021 to 3/12/2021. The facility was not found in compliance with the requirement CFR 483.73, Emergency Preparedness, and was cited at E0001. Event ID # JJGM11.	E 000		
E 001 SS=F	Establishment of the Emergency Program (EP) CFR(s): 483.73 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: This REQUIREMENT is not met as evidenced	E 001		4/27/21

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

Electronically Signed | 04/05/2021

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E 001	Continued From page 1 by: Based on record review and staff interviews, the facility failed to review and maintain a comprehensive Emergency Preparedness (EP) plan. The facility failed to maintain and update the EP plan, update for current contacts, address EP collaboration, collaborate with local stakeholders, update or review for arrangements with other facilities, review and update the communication plan, update names and contact information, share information with residents or family members, put into place EP training, and document information in the EP regarding the emergency generator. Findings included: Review of a sign in sheet from the Morning Meeting dated 3/5/21 revealed there were six department heads present, including the Administrator. There was an additional, undated page, and under "Meetings" there was a hand written note which documented, "Review of FA (Facility Assessment) and EPP (Emergency Preparedness Plan)." A review completed of the facility's Emergency Preparedness plan material on 3/11/21 revealed: A. The EP plan had not been reviewed or updated annually. The current Administrator or the current Director of Nursing were not listed in the EP plan. B. The EP plan was not updated for current contacts. C. The EP plan did not address the procedures for EP collaboration with local, tribal, regional,	E 001	The facility failed to review and maintain a comprehensive emergency preparedness plan. On 3/29/21 the Administrator reviewed and updated the Emergency Preparedness Plan(EPP), added the information for the current Administrator and Director of Nursing (DON), updated current contacts, addressed procedures for EP collaboration and contact information for local tribal, regional, state and federal EP officials, communication plan, risk assessment, arrangements with other facilities, training plans, emergency generator, inspection, testing and fuel. All staff were re-educated on EPP training plans on 4/2/21 by Staff Development Coordinator (SDC) or designee. All newly hired staff will be educated on EPP training plans by the SDC or designee at orientation. Any staff member that has not been trained by 4/2/21 will not be able to work. The EPP will be reviewed and implemented at the next monthly QAPI. The Administrator will maintain and update the EPP Plan as needed throughout the year for changes at the facility. The EPP will be updated at least annually and reviewed by the QAPI Team. The Administrator is responsible for this plan of correction.	

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E 001	Continued From page 2	E 001		

state and Federal EP officials.

D. Policies and procedures regarding the EP plan policies and procedures, based on the emergency plan for risk assessment and the communication plan were not reviewed and updated annually.

E. The EP plan was not currently updated or reviewed for arrangements with other facilities.

F. The EP plan for communication was not current, reviewed, nor updated.

G. The names and contact information were not current, reviewed, nor updated which were contained in the EP plan.

H. The names and contact information contained in the EP plan for emergency officials contact information was not reviewed or updated.

I. The EP plan did not establish methods in place for sharing information from the emergency plan with residents or family members.

J. The facility failed to develop and put into place EP training plans.

K. The EP plan lacked information regarding the emergency generator location, inspection, testing, and fuel.

An interview was conducted with the Administrator and the Regional Director (RD) on 3/11/21 at 3:16 PM. The RD stated the Emergency Preparedness manual had been reviewed by the current administrator and the former administrator but there was no

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E 001	Continued From page 3 documentation where it had been signed as reviewed. The Administrator stated she had experience with the Emergency Preparedness manual from a previous facility but had only been at her current facility for three weeks and had not signed off on the Emergency Preparedness manual that it had been reviewed. The Administrator was unable to provide documentation where the former Administrator, current Director of Nursing (DON), former DON, current Maintenance Director, former Maintenance Director, or herself had signed off the Emergency Preparedness manual as having been reviewed and updated. The Administrator was unable to locate in the manual where contact information for the current administrative or former administrative staff had been updated and put into the Emergency Preparedness manual. The Administrator was unable to provide information regarding when the facility staff had been provided Emergency Preparedness training. The Administrator did state she had reviewed the Emergency Preparedness manual during the morning meeting on 3/5/21 as part of the preparation for the potential of an upcoming recertification survey.	E 001		
F 000	INITIAL COMMENTS A recertification and complaint survey was conducted 3/7/2021 to 3/12/2021. Event ID #JJGM11. 32 of 82 complaint allegations were substantiated and 2 of 82 complaint allegations were rescinded by the complainant.	F 000		
F 563 SS=D	Right to Receive/Deny Visitors CFR(s): 483.10(f)(4)(ii)-(v) §483.10(f)(4) The resident has a right to receive	F 563		4/27/21

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F 563	Continued From page 4 visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. (ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time; (iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time; (iv) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and (v) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation. This REQUIREMENT is not met as evidenced by: Based on record reviews, family member interview, and staff interview, the facility limited end-of-life visitation for the convenience of the facility and failed to notify family a resident was actively dying for 1 of 1 residents reviewed for visitation (Resident #469A). Findings included:	F 563	The facility limited end of life visitation and failed to notify family a resident was actively dying. On 3/30/21 the social worker sent letters to all alert and oriented residents and family members of current residents regarding the Centers of Disease Control and Prevention(CDC)guidance on facility visiting procedure. On 3/29/21 visitation	

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F 563	Continued From page 5 Resident #469A was admitted to the facility 1/6/2020 with diagnoses to include heart failure, hypertension and liver disease. The most recent quarterly Minimum Data Set (MDS) assessment dated 5/22/2020 assessed Resident #469A to be severely cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 7. Resident #469A was assessed to have no issues hearing or speaking. A care plan dated 5/20/2020 and revised 5/28/2020 identified Resident #469A as having elected comfort care. A care plan dated 5/27/2020 addressed Resident #469A ' s terminal diagnoses with intervention to provide Resident #469A with maximum comfort. A nursing note date 6/5/2020 at 10:45 PM written by Nurse #6 was reviewed. The note documented "resident (#469A) continues to decline ...family is aware." A nursing note dated 6/6/2020 at 4:30 AM written by Nurse #8 documented Resident #469A had died, and the family member was on her way to the facility. A grievance dated 6/19/2020 was reviewed. The grievance documented that family members of Resident #469A were "not treated well and were informed they should only come (to visit Resident #469A) when a receptionist was working." A statement written by the former Business Office Manager (BOM) (no date) was reviewed. The note documented that the family of Resident #469A arrived at the facility on 6/5/2020 at 1:30 PM. The family member reported she had been	F 563	procedure letter was added to the facility admission packet by the Admissions Director. On 03/31/21 the Director of Nursing (DON)or designee completed a 100% audit of residents in the facility for any residents actively dying in the facility. Findings reflected no residents were actively dying. On 4/2/21 the Staff Development Coordinator(SDC)completed re-education with nursing staff and receptionists on allowing family visit when a resident is at end of life and notification to family when a resident is actively dying. All newly hired nursing and receptionist staff will be educated on the end-of-life visitation procedure during orientation by the SDC or designee. Any staff not educated by 4/2/21 will not work until education is complete. The Director of Nursing or designee will audit residents weekly x 3 months beginning 4/8/2021. Audits will be documented on the end-of-life visitation log to ensure family members are notified and allowed to visit residents at end of life. The visitation log will be brought to monthly Quality Assurance and Performance Improvement Committee x 3 months by the DON or designee for review. Any further action needed will be implemented by the committee as required.	

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F 563	Continued From page 6	F 563		

notified that Resident #469A was not doing well and she wanted a compassionate care end-of-life visit with Resident #469A. The BOM documented that after consulting with the floor nurse and the former Administrator, the family was permitted to visit Resident #469A, after they had been screened for COVID-19 and applied personal protective equipment. The note documented that the former Administrator had instructed the BOM that only 2 family members could visit at a time and only immediate family could visit Resident #469A. The note documented the MDS nurse had assessed Resident #469A and did not feel that Resident #469A was actively dying. The BOM documented visiting hours would end at 5:00 PM on 6/5/2020 and would be 8:00 AM to 2:00 PM during the weekend. The note documented a list of approved visitors was left for the receptionist and the floor nurse, as well as written instructions regarding the specific visiting hours.

A family member for Resident #469A was interviewed by phone on 3/8/2021 at 11:18 AM. The family member reported the family was made aware that Resident #469A was declining on 6/5/2020, but they were told by the MDS nurse that she was not actively dying. The family member reported she was under the impression that Resident #469A would not die immediately and she thought she had the weekend to visit with Resident #469A. The family member reported that she was upset because the family was not able to stay with Resident #469A and that Resident #469A died alone.

Nurse #8 was interviewed by phone on 3/9/2021 at 4:40 PM. The nurse reported she did not remember Resident #469A. Nurse #8 stated she would not have notified Resident #469A ' s family

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F 563	Continued From page 7	F 563		

she was actively dying because of the COVID-19 pandemic visitation restrictions and because the family had been provided with a visit earlier in the day.

The former Administrator was interviewed on 3/9/2021 at 4:57 PM. The former Administrator reported there were a lot of family dynamics with Resident #469A and to control the situation, she limited the amount of time the family could visit, as well as the number of people who could visit. The former Administrator reported due to staffing, the facility did not have staff available to monitor the activity of the family members in the facility and she would not permit the family to stay overnight with Resident #469A.

Several attempts were made to interview the former BOM but were unsuccessful.

The former MDS nurse was unavailable for interview.

The Administrator was interviewed on 3/10/2021 at 11:35 AM. The Administrator reported she was not working at the facility at the time of Resident #469A ' s death, but she had reviewed the grievance documentation and investigation. The Administrator reported based on the documentation, the facility accommodated the family members of Resident #469A and permitted them to visit with her prior to her death.

Nurse #6 was interviewed on 3/10/2021 at 1:11 PM. Nurse #6 reported she was able to recall Resident #469A and she took care of Resident #469A on 6/5/2020. Nurse #6 reported she had been instructed by the former Administrator to make Resident #469A ' s family leave at 5:00 PM

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F 563	Continued From page 8 on 6/5/2020 and they were not to return until 6/6/2020 during the agreed visiting hours because the facility did not have the staff to monitor the visitors. Nurse #6 reported that Resident #469A was dying when she left the facility at the end of her shift.	F 563		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups.	F 565		4/27/21

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F 565	Continued From page 9 §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews the facility failed to resolve repeated concerns reported during resident council meetings for three consecutive months reviewed for resident council. (October 2020, November 2020, and December 2020). Findings included: The Resident Council Meeting Minutes from October 2020 to February 2021 were reviewed. The review revealed the following concerns were voiced during the monthly Resident Council meetings: Review of the Resident Council Meeting Minutes from October 21, 2020 reported concerns related to: A. Residents not getting what you ordered off your meal ticket, no condiments being on the meal tray and warm coffee. B. Residents discussed missing items from laundry, running out of linens and needing more pads. C. Answering call bells in a timely manner and choice of when to get up. D. Residents asked for a different variety of snacks. E. Residents asked about a better smoking arrangement for residents that smoke. There was no documented response the	F 565	Facility failed to respond to grievances that were reported by the resident council during meetings for 3 of 3 consecutive months. On 4/1/21 grievances were completed for reported concerns from the identified resident council meetings and responses were provided for concerns to resident council members in attendance on the 4/1/21 resident council meeting by the social worker. Interview completed on 3/30/21 by social worker with Resident #4, #49 and #25 indicates they are receiving snacks. Interview on 03/30/21 by housekeeping director with Resident #4 indicated he received his missing paints. On 3/30/21 the Administrator re-educated the Activities Director and Social Worker on grievance procedure for resident council. On 4/1/2021 the Administrator asked the resident council to change their monthly meeting schedule to bi-monthly x 2 months, beginning 4/14/21 then reverting to a monthly schedule thereafter. This will allow center staff to be more responsive to council requests. The Administrator or designee will ensure that staff assignments are made in developing and providing an administrative response to each concern or request raised by the council, no later	

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F 565	Continued From page 10 concerns were acted upon by the facility. Review of the Resident Council Meeting Minutes from November 18, 2020 reported concerns related to: A. Residents not getting what you ordered off your meal ticket, no condiments being on the meal tray and warm coffee. B. Residents discussed missing items from laundry, running out of linens and needing more pads. C. Answering call bells in a timely manner and choice of when to get up There was no documented response the concerns were acted upon by the facility. Review of the Resident Council Meeting Minutes from December 18, 2020 reported concerns related to: A. Residents had concerns about laundry and not getting items back from laundry B. Resident concerns about room changes. C. Resident concerns about not receiving snacks at night D. Residents have concerns about when visitation will open back up for family and friends There was no documented response the concerns were acted upon by the facility. During a resident council meeting on 3/8/21 at 1:30 PM when the resident council participants were asked question #5 "Does the facility consider the views of the resident or family groups and act promptly upon grievances and recommendations" the resident council present responded "sometimes and sometimes not." 3 out of the 4 residents (#4, #49 and #25)	F 565	than next business day after each council meeting on the grievance log. These responses will be reviewed by the Administrator no later than 1 week following each council meeting for approval x 3 months. If the council raises a request that cannot be addressed by the facility, the Administrator will request the councils permission to address the council and will provide to the council a written explanation of same. Grievances presented by the council will be brought to the Quality Assurance & Performance Improvement (QAPI) committee monthly on the grievance log by the Administrator. Any further action needed will be implemented by the committee as required. The Administrator is responsible for implementing the acceptable plan of correction.	

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F 565	Continued From page 11 commented they did not receive snacks or even knew about snacks. Resident #4 said he is missing several of pairs of pants and has tried to talk to the laundry department himself. An interview was completed on 3/8/21 at 2:18 PM with the Activities Coordinator (AC). A review of the concerns from the October, November and December meeting was reviewed. The AC stated that she could not answer as to why a resident council concern follow up form was not completed for those months and thought she had forwarded the concern to laundry. A phone interview was completed with the administrator on 3/12/21 at 11:50 AM who stated it is her expectation that the facility follows the Centers for Medicare & Medicaid Services regulatory guidelines.	F 565		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for	F 584		4/27/21

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F 584	Continued From page 12 the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to maintain clean shower rooms, clean shower equipment, failure to maintain shower heads, sprayers and operable lights, and maintain clean shower stalls with intact floor tiles in 3 of 3 shower rooms observed for environment. Findings included: 1. Three observations were conducted on 3/7/2021 at 11:15 AM, 3/8/21 at 10:50 AM and 3/9/21 at 10:25 AM of the 100-hall shower room which included two shower stalls and shower	F 584	The facility failed to appropriately maintain resident shower rooms in 3 of 4 shower rooms. On 4/1/21 the maintenance director replaced the missing shower head, hand held sprayer and 1x1 floor tiles in the 100 hall shower room. On 3/9/21 the environmental director cleaned the shower room floor and equipment and removed all linen and trash in the 100 hall shower room. On 3/9/21 the environmental director cleaned the 600 hall shower room. On 4/1/21 the maintenance director repaired the hand	

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F 584	Continued From page 13 equipment. The right shower stall had a missing shower head but did have a handheld shower sprayer and had 8 chipped 1x1 floor tiles along with black spots on the shower floor. The shower stall on the left had a shower head but no hand-held sprayer head. The shower chair had reddish brown marks on the back area of the seat. Located on a bathing bed was a towel and on a seated scale chair had a towel, one plastic glove, a resident gown and a gray nylon vest wadded in the seat of the chair. 2. An observation was conducted on 3/7/2021 at 1:07 PM, of the 600-hall shower room which revealed puddles of water in the middle of the floor with brown rings around them approximately 2 ½ by 1 ½ ft in diameter and a second puddle which was 5 x 7 inches in diameter. The shower room had two shower stalls, a standing lift and wheelchair. The shower stall on the right had a hand- held sprayer that was not hooked up and a shower light in the stall that did not work. The shower stall on the left had dark black spots on the caulking on the perimeter of the shower floor. The standing lift had an enormous amount of black substance on the plastic portion of the lift which one could see when standing on the lift. The wheelchair had gloves, 1 brief and an open box of razors on the seat of the wheelchair. An observation was completed on 3/8/21 at 10:38 AM of the 600-hall shower room revealed the shower stall on the right had a hand- held sprayer that was not hooked up and a shower light in the stall that did not work. The shower stall on the left had dark black spots on the caulking on the perimeter of the shower floor. The standing lift had an enormous amount of black substance on the plastic portion of the lift which one could see when standing on the lift. The wheelchair had	F 584	held sprayer and the shower light. On 4/1/21 the maintenance director replaced the shower stall caulking in the 600 hall shower room. On 3/9/21 the environmental director cleaned the standing lift and removed glove and brief. On 3/9/21 the environmental director disposed of the hair products, shampoo and briefs in 300 Hall shower room. On 4/1/21 the maintenance director conducted an audit of all shower rooms to ensure resident shower areas and equipment were properly maintained, clean and sanitized. On 4/1/21 the maintenance director conducted an audit of all lifts to ensure all lifts were clean. On 4/2/21 the Staff Development Coordinator completed in service for all Nursing, Housekeeping, Laundry Staff, Rehab Staff, Dietary Staff and Department Managers on the following procedures: The resident has a right to a safe, clean, comfortable, and homelike environment including but not limited to receiving treatment and supports for daily living safely. -The importance of maintaining resident shower areas, equipment and cleaning and sanitizing after each use. -The importance of inspecting and reporting any signs of equipment not in proper working order. All newly hired staff will be educated on the right to a safe, clean, comfortable, and homelike environment during orientation by the SDC or designee. Any staff member not in-serviced by 4/2/21 will not be able to work until completion of education.	

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F 584	Continued From page 14 gloves and 1 brief on the seat of the wheelchair. An observation was completed on 3/9/21 at 1:41 PM revealed the shower stall on the right had a hand- held sprayer that was not hooked up and a shower light in the stall that did not work. The shower stall on the left had dark black spots on the caulking on the perimeter of the shower floor along with 3 brown clumps on the shower floor. The standing lift had an enormous amount of black substance on the plastic portion of the lift which one could see when standing on the lift. The wheelchair had gloves and 1 brief on the seat of the wheelchair. 3. An observation was conducted on 3/7/2021 at 2:07 PM, 3/8/21 at 11:55 AM and 3/9/21 at 10:51 AM of the 300-hall shower room which had a shower stall, a freestanding whirlpool tub. The shower stall 2 bottles of hair products. The whirlpool tub had an empty bottle of shampoo and 2 briefs lying inside the tub. A record review was completed of the maintenance work orders from December 1, 2019 to March 8, 2021. It revealed four work orders had been completed for the 100 and 600 hall shower rooms. The 100-hall shower room maintenance requests were for a shower head that would not hang up and to fix the side shower head. These were completed in January and February of 2020. The 600-hall shower room had a maintenance requests for a leaking shower head and a shower head that needed to be changed. These were completed in December 2019 and January 2020. An interview was completed with a NA #8 in the 600-hall shower room on 3/9/21 at 1:41 PM who stated the NA is responsible for cleaning and	F 584	The Maintenance Director, Environmental Services Director or designee will conduct audits on Shower Rooms to ensure shower areas and shower equipment is properly maintained, sanitized and are in good working order. The Environmental Services Director or designee will conduct audits on lift equipment to ensure lift equipment is clean. These audits will be completed 5x weekly for 4 weeks and 1x weekly for 2 months to include weekends. The shower room audit tool and lift audit tool will be brought to QAPI x 3 months by the maintenance director, environmental services director or designee for review any further action needed will be implemented by the committee as required. The Maintenance Director is responsible for implementation and completion of the acceptable plan of correction.	

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sanitizing the shower equipment after each use.

An interview was completed with a Housekeeping Aide (HA) on 3/10/21 at 7:10 PM who stated that Housekeeping is to clean the bathrooms in the showers and make sure and get the corners as well as the shower chairs. HA stated they are cleaned in the morning but can also be cleaned at night. HA stated there is not a schedule for cleaning the showers but stated they are done every other day if not daily. HA stated that the nurse or nurse's aide would call the Housekeeping department if there would be any fecal matter left in the shower and we would clean it up.

On 3/9/21 at 5:10 PM an observation was conducted in conjunction with an interview with the Administrator, Maintenance Manager and Housekeeping Manager of the 100, 300, and 600 shower rooms which revealed the 100 hall shower room in the right shower stall had a hand held shower sprayer, a missing shower head and had 8 chipped 1x1 floor tiles along with black spots on the shower floor. The shower stall on the left had a shower head but no hand-held sprayer head. The shower chair had reddish brown marks on the back area of the seat. Located on a bathing bed was a towel and on a seated scale chair had a towel, one plastic glove, a resident gown and a gray nylon vest wadded in the seat of the chair. The 300-hall shower room revealed the shower stall on the right had a 2 bottles of hair products. The whirlpool tub had an empty bottle of shampoo and 2 briefs. An observation of the 600-hall shower room the shower stall on the right had a hand- held sprayer that was not hooked up and a shower light in the stall that did not work. The shower stall on the left had dark

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F 584	Continued From page 16 black spots on the caulking on the perimeter of the shower floor along with brown clumps on the shower floor. The wheelchair had gloves and 1 brief on the seat of the wheelchair. The Maintenance Manager stated that all areas of concern would be taken care of. A phone interview was completed with the Maintenance Manager on 3/11/2021 at 3:42 PM and reviewed the work orders from 2019 and 2020. He stated he was not working at the facility at the time but stated they had all been completed and there had been no further work orders for the shower rooms.	F 584		
F 585 SS=B	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.	F 585		4/27/21

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§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being

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F 585	Continued From page 18 investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interviews the facility failed to provide a written response of the grievance resolution to the resident or the residents responsible party regarding grievances that was filed for 1 of 1 resident reviewed for grievances. (Resident #47)	F 585	F 585 The facility failed to provide a written grievance summary for 1 of 1 resident. On 3/30/21 the social worker provided resident #47's power of attorney a written response to 3 of 3 grievances filed between 2/1/2020 through 2/1/2021.	

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F 585	Continued From page 19 Findings Included: A review of the facility's policy related to grievances revealed the following: Policy dated December 1, 2017 and revised on August 2018 titled "Grievances Quality of Life", reads in part, "the resident will be provided a written summary of the resolution. An acknowledgement signed by the resident validating he or she has received a written response will be maintained with the grievance". A review of the complaint/grievance report for resident #47 from 2-1-2020 through 2-1-2021 revealed three grievances were filed on behalf of resident #47 and results were communicated verbally. The facility failed to issue a written response to the resident's or their responsible party concerning the grievance resolution. An interview was conducted with the facility social worker (SW) on 3/9/21 at 4:53 PM who stated she did not know she needed to send written responses for grievance resolutions. A phone interview was completed with the administrator on 3/12/21 at 11:50 AM who stated it is her expectation that the facility follows the Centers for Medicare & Medicaid Services regulatory guidelines	F 585	All staff completed an in-service on the right to file grievances, how to file a grievance and the location of grievance forms by the SDC on 4/2/21. All newly hired staff will be educated on the grievance procedure during orientation by the SDC or designee. Any staff member not in-serviced by 4/2/21 will not be able to work until completion of education. Residents were provided a letter with instructions on the right to file grievances, how to file a grievance and the location of grievance forms by the social worker on 3/29/21. On 3/29/21 a copy of the grievance form was placed in the Admission's packet. On 3/30/21 the Administrator sent a letter to all responsible parties with instruction on the right to file grievances, how to file a grievance and the location of grievance forms at the facility. The interdisciplinary team will monitor all grievances daily in morning meeting to ensure proper policy and procedure and regulatory compliance. Copies of the grievance log will be submitted to the Quality Assurance Performance Improvement Committee (QAPI) monthly for three months, to ensure proper compliance and reassess the need for ongoing monitoring. The person responsible for this plan of correction is the Administrator.	
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that	F 637		4/27/21

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F 637	Continued From page 20 there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to complete a significant change in status Minimum Data Set (MDS) assessment within 14 days of Hospice election for 1 of 2 (Resident #36) residents reviewed for Hospice. The findings included: Resident #36 was admitted to the facility on 3/6/20 with diagnoses of palliative care, dementia and failure to thrive. A Facility Status Form dated 1/27/21 was reviewed and indicated Resident #36 received Hospice services that started on 1/27/21. A record review revealed a quarterly MDS assessment was completed on 1/2/21. A comprehensive medical record review did not indicate a significant change in status assessment MDS was completed within 14 days after the Hospice election. On 3/10/21 at 11:35 AM an interview was conducted with the Regional MDS nurse who stated many staff members quit after the COVID	F 637	The facility failed to complete a significant change in minimum data set (MDS) assessment within 14 days of Hospice election for 1 of 2 residents. A significant change in status assessment was completed for resident #36 regarding admission to Hospice Care on 3/31/21 by the MDS Coordinator. The Director of Nursing or Staff Development Coordinator audited Minimum Data Set (MDS) assessments for current residents receiving hospice services to ensure a significant change in status assessment was completed as appropriate. Any assessments not incompliance was modified or completed. The Clinical Reimbursement Manager (Regional MDS Nurse) reeducated the facility MDS nurse on completion of a significant change in status assessment for any resident that requires admission to Hospice care on 03/30/21 The Director of Nursing or Designee will audit 10% of weekly MDS's for significant change in status assessment for need of admission to Hospice Services prior to	

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F 637	Continued From page 21 outbreak in December and the former MDS nurse was pulled to take care of the residents. She added she was sure the errors were oversights.	F 637	transmission for 3 months. The Director of Nursing will submit results of the audits to the monthly Quality Assurance Performance Improvement Committee meeting for review and need for ongoing monitoring. The person responsible for this plan of correction is the Director of Nursing.	
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 record review and staff interviews, the facility failed to code the Minimum Data Set Assessment correctly for 1 of 3 Residents (Resident #70) reviewed for discharge and 1 of 2 Residents (Resident #14) reviewed for hospice services. 1. Resident #70 was admitted to the facility on 02/06/21 with diagnoses that included COVID-19, pneumonia, cystitis, obesity, anxiety, depression, diabetes and rheumatoid arthritis. She was discharged home on 02/19/21. Resident #70's MDS assessment dated 02/8/21 coded the resident as being cognitively intact. Review of the Discharge MDS assessment completed on 02/19/21 indicated Resident #70 had been discharged to the hospital. A record review revealed a Physician order was written on 02/17/21 for Resident #70 to discharge home on 2/19/21 with home health, physical	F 641	The facility failed to code the minimum data set assessment correctly for 1 of 3 residents. Resident #70 Minimum Data Set (MDS) was modified by the MDS Coordinator to reflect accurate coding on 3/11/21. Resident # 14 MDS was modified by the MDS Coordinator to reflect accurate coding on 3/31/21. The Director of Nursing(DON) or designee completed audit of MDS Assessments completed in the last 3 months to ensure discharge (MDS section A2100) and hospice services (MDS Section J1400) is accurately coded on 3/31/2021. Any negative findings were modified on 3/31/21. The Clinical Reimbursement Manager (Regional MDS Nurse) reeducated the facility MDS Coordinator on the Resident Assessment Instrument (RAI) for MDS Section J and Section A on 3/30/21.	4/27/21

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F 641	Continued From page 22 therapy, occupational therapy and a home health nurse to assess and treat. A record review of the Physician Discharge Summary completed by the Physician Assistant on 02/16/21 documented that the resident would be discharged to home in fair and stable condition with a family member. A phone interview with the Social Worker (SW) was done on 03/10/21 and she indicated Resident #70 was discharged home with a family member. She reviewed Resident #70's medical record and stated that on her baseline care plan the resident had planned to go home, and a progress note from 02/16/21 noted that the discharge plan continued for her to go home with a family member. Attempts were made to contact the MDS nurse who had completed the discharge MDS assessment were unsuccessful. A phone interview was conducted with Regional Nurse Consultant #1 on 03/13/21 at 8:09 AM, regarding Resident #70's discharge. She said she had reviewed the unscanned discharge paperwork and the resident had gone home. She stated all MDS assessments were to be coded correctly and she would have expected the correct discharge location to be entered. The Director of Nursing was interviewed on 03/11/21 at 4:03 PM regarding the MDS assessment for Resident #70. She indicated the MDS should be coded accurately. She said she would expect the MDS nurse to know how to code the MDS correctly. The Administrator and Regional Corporate	F 641	The DON or designee will audit 10% of MDS assessments coded for section J1400 and A2100 weekly for accuracy prior to transmission weekly for 3 months beginning 4/8/21. Director of Nursing will submit results of the audits to the monthly Quality Assurance Performance Improvement Committee meeting for review and need for ongoing monitoring. Any further action needed will be implemented by the committee as required. The person responsible for this plan of correction is the Director of Nursing.	

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F 641	Continued From page 23 Consultant #1 were interviewed on 03/11/2021 at 4:28 PM. It was stated that the MDS Nurse should have followed the RAI Manual guidelines and the MDS should be accurate. 2. Resident #14 admitted to the facility on 1/24/2020 and had diagnoses of chronic kidney disease, dementia and heart failure. A quarterly Minimum Data Set (MDS) assessment dated 11/26/2020 indicated Resident #14 received hospice services but did not indicate they had a life expectancy of less than 6 months. A Care Plan updated on 11/30/20 indicated Resident #14 had a terminal illness of End Stage Renal Disease and had elected hospice services. An order dated 4/28/20 revealed Resident #14 began Hospice services. During an interview on 3/12/2021 at 9:11 am, the MDS Regional Coordinator stated the quarterly Minimum Data Set (MDS) assessment dated 11/26/2020 should have included Resident #14's life expectancy of less than 6 months. The MDS Coordinator should have reviewed the documentation from Hospice Services which would have this information.	F 641		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;	F 677		4/27/21

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F 677	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to provide a dependent resident with incontinence care (Resident #29), failed to provide showering and shaving assistance (Resident #30), and failed to provide nail care (Resident #20) for 3 of 9 residents reviewed for Activities of Daily Living. Findings included: 1. Resident #29 was admitted to the facility on 9/11/2021 with a diagnosis of quadriplegia. The most recent quarterly Minimum Data Set (MDS) assessment dated 1/2/2021 assessed Resident #29 to be severely cognitively impaired and she required total assistance with bed mobility, toileting, hygiene and bathing. The MDS also indicated that Resident #29 was non-verbal and always incontinent of bowels and bladder. The care plan for Resident #29 dated 2/19/2018 with a revision date of 1/14/2021 addressed Resident #29's need for total assistance with bed mobility, toileting, hygiene, and bathing to prevent skin breakdown and interventions included to reposition Resident #29 frequently in bed and provide incontinence care. Resident #29 was observed on 3/9/21 at 9:48PM in her room in bed. There was a very pungent odor of urine the room and the bed linens were wet. Incontinence care for Resident #29 was observed on 3/9/2021 at 10:26 PM. The odor of urine was noted upon entering the room. The bottom sheet on the bed was noted to be wet and stained with	F 677	The facility failed to provide dependent resident with incontinence care, showering and shaving assistance, nail care for 3 out of 9 residents. On 03/9/21 resident #29 was provided incontinence care by nursing assistant (NA). On 4/1/21 resident #20 was provided nail care by NA. Resident #30 received a shower and was shaved on 3/12/21 by NA. 100 % audit of all residents to include resident # 29, resident #20 and resident #30 was completed on 4/1/21 by the Director of Nursing (DON) or designee to ensure assistance was provided with incontinence care, nail care, showers, and shaving. Any identified areas will be addressed during audit by the DON or designee to include updating care plan/guide. A 100% in-service was completed with all nurses, med aides and nursing assistants on 4/2/21 by DON or designee related to reading and following care guide prior to starting care to determine if the resident requires assistance with incontinence care, nail care, showers, and shaving. All newly hired nursing staff will receive education during orientation by the Staff Development Coordinator (SDC) or designee on providing resident ADL assistance as per resident care guide/care plan. Any staff member that has not received education by 4/2/21 will not work until educated by the SDC or designee. 10% audit of all residents to include	

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F 677	Continued From page 25 a dark yellow ring that was under Resident #29's lower back, buttocks and upper legs to her knees. The lift sheet under Resident #29 was wet. The incontinence brief was saturated, and the odor of urine was overpowering during care. Nursing assistant (NA) #6 was interviewed on 3/9/2021 at 10:55 PM. NA #6 reported she started her shift at 6:00 PM. NA #6 reported when she arrived for her shift, the residents were receiving their evening meal. NA #6 reported she provided eating assistance to residents, picked up the meal trays and once she finished those activities, she started providing bedtime incontinence care to residents. NA #6 reported she started at the top of the hall (room 501) and worked her way to the back to complete her care. NA #6 described care for Resident #29 included turning and repositioning every 2 hours as well as incontinence care. NA #6 stated she had not provided any care to Resident #29 from 6:00 PM until 10:30 PM because she was very busy with other residents. Additionally, NA #6 reported Resident #29 was a "heavy wetter" and she required changing more frequently. NA #6 reported she should have provided incontinence care to Resident #29 earlier in the shift. The Director of Nursing (DON) was interviewed 3/10/2021 at 11:35 AM. The DON reported the NAs who started work at 6:00 PM were expected to complete incontinence care every 2 hours and NA #6 should not have left Resident #29 to the end of her bedtime incontinence rounds. The DON reported she expected all residents to be kept clean and dry and to have incontinence care at least every 2 hours. The DON reported NA staffing for the hall was 1 NA and 1 floating NA (who worked all halls) plus a nurse passing	F 677	resident # 29, #30 and # 20 will be observed by DON or designee to ensure residents receive assistance with incontinence care, nail care, shaving care and showers as per resident care guide weekly x 8 weeks utilizing the resident care audit tool, then monthly x 1 month. For any identified areas of concerns resident(s) will be provided assistance and staff will be reeducated. DON or designee will review and initial the audit tools for completion and ensure any identified concerns were addressed. Weekly audits will be initiated by the DON on 4/8/21. DON or designee will forward the results of audits to the QA Committee monthly x 3. The QA Committee will review resident care audit tools monthly x 3 to determine trends and / or issues that may need further interventions put into place and to determine need for further and / or frequency of monitoring. The person responsible for implementing this plan of correction is the DON.	

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medications. The DON reported NA #6 should have provided care to Resident #29 before bedtime.

3. Resident #20 was admitted to the facility on 12/16/16 with diagnoses of, in part, cerebral infarction with hemiplegia and depression.

A review of a 5 day Minimum Data Set (MDS) dated 12/18/20 revealed Resident #20 had moderately impaired cognition and required extensive to total assistance for activities of daily living. Resident #20 had a limitation in range of motion to his upper extremity on one side.

Resident #20 ' s care plan indicated a focus on activities of daily living self-care deficit related to his hemiplegia, limited mobility, limited range of motion and previous cerebrovascular accident with a goal to maintain current level of functioning in activities of daily living through the next review. Interventions included encourage resident to participate in tasks, ensure effective pain management prior to activities of daily living and provide cues.

An observation on 3/7/21 at 1:49 PM revealed Resident #20 lying in bed with long fingernails that appeared to have dirt under them. Resident #20 nodded his head that he would like to have his fingernails cut and cleaned.

An observation on 3/8/21 at 8:39 AM revealed Resident #20 lying in bed eating breakfast. The resident ' s nails were still long and appeared dirty.

An observation on 3/9/21 at 1:15 PM revealed Resident #20 out of bed to his wheelchair

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dressed in shorts and a t-shirt. Resident #20 ' s fingernails were still long and appeared dirty underneath.

On 3/10/21 at 2:30 PM, an interview was conducted with NA# 1. She stated nurses and nursing assistants were responsible for nail care, but she was unsure if the facility had someone from outside come in to do nail care. She stated she did know how to complete nail care but she had not cleaned or cut Resident #20 ' s nails recently.

On 3/10/21 at 2:45 PM, an interview was conducted with the interim Director of Nursing who stated nail care should be done during bathing and nurses and nursing assistants should be cutting the residents fingernails.

2. Resident #30 admitted to the facility on 9/23/2019 with diagnoses of kidney disease and liver failure.

A quarterly Minimum Data Set (MDS) assessment dated 1/3/2021 revealed Resident #30 was cognitively intact and required extensive assistance with bathing and personal care.

A review of the March 2021 Activities of Daily Living (ADL) record revealed Resident #30 did

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F 677	Continued From page 28	F 677		

not receive a shower from 3/1/2021 to 3/11/2021.

An interview was conducted with Nurse Aide #2 on 3/10/2021 at 9:08 am revealed she cared for Resident #30 frequently. Nurse Aide #2 stated she was not able to give everyone a shower before this week because she had a whole hall which was two assignments to care for and she did the best she could giving everyone a bed bath. She stated Resident #30 had not complained about not receiving a shower or being shaved.

During an observation and interview with Resident #30 on 3/10/2021 at 9:23 am he stated he had not had a shower for the past 3 months. He stated he would like a shower twice a week and would like to be shaved when he has a shower. Resident #30 had an approximate ¼ inch of beard growth on his face. Resident #30 stated he had not complained to anyone about not getting a shower because he stated it would not do any good.

An observation on 3/11/2021 at 8:17 am revealed Resident #30 was in bed and he continued to have ¼ inch of beard growth but he was in a clean gown and he stated the Nurse Aide gave him a good bed bath but did not offer to take him to the shower or shave him.

During an interview with the Administrator on 3/11/2021 at 9:23 am she stated she expected the facility staff to follow the Center for Medicare and Medicaid Services guidelines for resident care and nothing further to say about the staff not providing bathing or shaving for Resident #30.

On 3/11/2021 at 11:14 am the Director of Nursing

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F 677	Continued From page 29 was interviewed and stated Resident #30 should receive a shower twice a week and whenever he requested and should be shaved whenever he requested.	F 677		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, staff, wound care nurse practitioner and facility nurse practitioner interviews, the facility failed to implement physician orders to provide Resident #47 wound care. This failure was for 1 of 10 sampled residents reviewed for pressure ulcers. The findings included: Resident #47 was admitted to the facility on 9/24/18 with diagnoses of, in part, peripheral vascular disease, diabetes mellitus type 2 and kidney failure. An annual Minimum Data Set (MDS) assessment	F 686	The facility failed to implement physician orders for 1 of 10 residents. Resident #47 did not suffer any ill effects related to this incident. MD notified on 3/31/21 by DON of the omissions. An audit of the TAR was completed to ensure treatment orders for current residents with wounds are in place. An audit of TAR's was completed to ensure all orders on the TAR's signed off by the Licensed Nurses were completed for the month of March by DON or Designee by 4/1/21. Any variances were discussed with the attending physician by the DON or designee.	4/27/21

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F 686	Continued From page 30 dated 1/19/21 revealed Resident #47 had severely impaired cognition and was dependent on staff for his activities of daily living. Resident #47 was at risk for pressure ulcers, had no current pressure ulcers and had 1 unstageable deep tissue injury (DTI). Resident #47 ' s care plan dated 1/1/21 revealed a focus on potential for impairment to skin integrity due to decreased mobility, diabetes mellitus. The care plan was updated on 7/22/20 to add a DTI to left heel. Interventions included avoid scratching and keep hands and body parts from excessive moisture, follow protocols for treatment, keep skin clean and dry and utilize pressure reduction mattress to protect skin. A review of wound care notes by the wound care nurse practitioner revealed Resident #47 developed a DTI to his left heel on 12/8/20. The area measured 4 centimeters by 3 centimeters by 0 centimeters. Skin prep was ordered. A note by the wound care nurse practitioner dated 12/22/20 revealed the left heel DTI presented with 100 percent eschar and measured 1 centimeter by 3 centimeters by 0 centimeters. The area around the wound (periwound) was documented as reddened. Resident #47 ' s physician orders revealed the order for skin prep ordered on 12/8/20 was discontinued on 12/22/20. A new order to clean the left heel with wound cleanser and apply santyl with border gauze was dated 12/22/20. The order was revised the same day, 12/22/20 to clean left heel with wound cleanser and apply santyl and silver alginate with border gauze.	F 686	Education to current licensed Nursing staff regarding completion and signing of ordered treatment orders and implementation of physician treatment orders by DON or Designee by 4/2/21. New Employees will be in-serviced as part of orientation by the SDC or designee. Any staff member not in-serviced by 4/2/21 will not be able to work until completion of education. Director of Nursing or Designee will audit for implementation of TAR orders and missing TAR documentation weekly x 3 months. The findings will be reviewed in QAPI times 3 months. The DON is responsible for implementing the plan of correction.	

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A review of the Treatment Administration Record (TAR) for December 2020 revealed Resident #47 did not receive treatment to the area to the left heel from 12/22/20 to 12/31/20.

An interview was conducted on 3/9/21 at 10:00 AM with Nurse #2 who stated she started work at the facility in December 2020 and became the wound nurse in January 2021. She stated prior to her, there was not a wound nurse and hall nurses had to do their own treatments. She was unsure what occurred with the order for treatment to Resident #47 ' s heel that was dated 12/22/20.

An interview was conducted with the wound care nurse practitioner on 3/11/21 at 9:02 AM. She stated she made weekly rounds on Resident #47 with the treatment nurse. She stated prior to the treatment nurse position being filled, she rounded with another nurse. She measured weekly. She stated Resident #47 developed a DTI to his heel that resolved in August 2020 and reappeared on 12/8/20. She added when she made recommendations for treatment changes, it was just that, a recommendation and the physician needed to approve it. She wasn ' t aware the treatment order dated 12/22/20 did not get implemented and stated the physician may not have approved it. She added Resident #47 had severe vascular disease and multiple other comorbitities, including COVID 19, that contributed to the poor healing and worsening of his wound.

On 3/12/21 at 9:26 AM, an interview was conducted with Resident #47 ' s nurse practitioner. He stated he relied on the wound care nurse practitioner and referd to her

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F 686	Continued From page 32 judgement to oversee the wounds and provide treatments accordingly and he did not get involved. He stated she had the expertise and he did not. He was unaware the treatment order dated 12/22/0 did not get implemented. He added Resident #47 had poorly controlled diabetes, vascular disease and dementia. He stated every time Resident #47 went to the hospital, his insulin orders were changed, and it was difficult to control once he returned to the facility. He did not believe the santyl not being applied for a couple of days would have caused the wound to worsen. On 3/12/21 at 10:49 AM, an interview was conducted with the Unit Manager who entered the order into the electronic health record on 12/22/20. She stated she did not know what the surveyor was talking about and was not at the facility. She abruptly ended the call.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observation, resident and staff interviews, the facility failed to determine the root cause of an accident when a bariatric bed turned over, a resident fell out of the bed and the facility continued to use the same bed. Additionally, the facility failed to use 2-person	F 689	The facility failed to determine the root cause of an accident when a bariatric bed turned over and a resident fell out of the bed. The facility failed to follow care guide assistance for bed mobility of 1 of 1 resident.	4/27/21

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F 689	Continued From page 33 assist for bed mobility for 1 of 1 residents reviewed for accidents (Resident #7). Findings included: Resident #7 was admitted to the facility on 7/13/2016 and readmitted on 7/24/2020 with diagnoses to include lung disease and diabetes. The most recent quarterly Minimum Data Set (MDS) assessment dated 11/3/2020 assessed Resident #7 to be cognitively intact without behaviors. The MDS assessed Resident #7 to require extensive 2-person assistance with bed mobility. Resident #7's bariatric bed limit was listed as 750 pounds on a sticker applied to the bed frame. The emergency room record dated 12/15/2020 documented Resident #7's weight as 342 pounds. A nursing note written by Nurse #10 dated 12/16/2020 at 12:01 AM documented Resident #7 was receiving care with 1 nursing assistant (NA) assisting and when Resident #7 turned over, the bed tipped over on its side, and Resident #7 fell to the floor, hitting her head. The note documented the family and the nurse practitioner had been notified and Resident #7 was sent to the hospital emergency room for evaluation. A nursing note date 12/16/2020 at 4:35 AM written by Nurse #10 documented Resident #7 returned to the facility and no injuries were identified in the emergency room. An attempt was made to contact the maintenance director who was on-staff at the time of the	F 689	Resident #7 was interviewed on 3/11/21 by nurse consultant. During interview resident stated bed was changed on day of incident when she returned from the hospital. A bed mobility assessment audit was completed on all bariatric residents by Occupational Therapist on 3/30/21. All bariatric residents bed mobility audit were shown to be in compliance according to their care plan. A bed audit was completed by the maintenance director for all residents on 4/1/21. All resident beds were shown to be in good working order and appropriate per resident size. A root cause analysis of accidents was completed by the interdisciplinary team (IDT) for all accidents in the month of March on 4/1/21. The staff development coordinator reeducated all nursing staff regarding safe resident handling and completing a work order and removing equipment identified to not be in proper working order on 4/2/21. The Administrator re-educated the IDT team on conducting root cause analysis of accidents on 3/29/21. All newly hired nursing staff will be educated regarding safe resident handling, removing equipment that is not in proper working order and completing a work order during orientation by the Staff Development Coordinator (SDC) or designee. Any staff member not in-serviced by 4/2/21 will not be able to work until completion of education. The Director of Nursing or designee will conduct 10% audits per week to include all shifts and weekends for 2 months, then	

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F 689	Continued From page 34 incident, and it was unsuccessful. An attempt was made to contact the NA who witnessed the incident, but the attempt was unsuccessful. Resident #7 was interviewed on 3/9/2021 at 10:06 AM. Resident #7 reported that on 12/15/2020 1 NA was assisting her and when Resident #7 rolled to the side, the bed lifted up and fell on its side. Resident #7 reported she fell to the floor when the bed tipped over. Resident #7 reported she hit her head and shoulder on the nightstand. The bed did not hit Resident #7 when it flipped. Resident #7 reported when she went to the emergency room, they did x-rays and a scan and did not find injuries or fractures and she was sent back to the facility. Resident #7 was interviewed again on 3/11/2020 at 6:30 PM and she reported the facility had taken the bed out of her room and she slept in a different bed when she returned from the hospital. Resident #7 reported the rail on the side of the bed that she used to turn was bent after the fall. Resident #7 reported the day after the fall, the maintenance department returned the bed to her and said there was nothing wrong with it and she thought the bed rail was straight. The current maintenance director (MTD) was interviewed on 3/9/2021 at 11:00 AM. The MTD reported no documentation was in maintenance records related to the incident on 12/15/2020 for Resident #7. The MTD reported there were no work orders related to Resident #7's bed. Nurse #10 was interviewed on 3/9/2021 at 9:56 PM. Nurse #10 reported she was working when Resident #7 fell out of bed on 12/15/2020. Nurse #10 reported she had not witnessed the bed	F 689	10% per month for 1 month on proper bed mobility for residents with the bed mobility audit tool beginning 4/8/21. A bed audit will be completed weekly x3 months by the maintenance director to ensure resident beds are in proper working order and place on the bed audit tool beginning 4/8/21. All accidents will be reviewed in morning meeting to discuss root cause by IDT and maintained on the accident log beginning 4/8/21. The Director of Nursing, Maintenance Director or designee will submit results to the monthly Quality Assurance Performance Improvement Committee meeting for review and need for ongoing monitoring. The person responsible for this plan of correction is the Administrator.	

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	345011	A. BUILDING _____ B. WING _____	C 03/18/2021

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F 689	Continued From page 35	F 689		

tipping over but was called to the room after the incident and the bariatric bed was tipped over on its side and Resident #7 was on the floor.

The Unit Manager (UM) was interviewed on 3/10/2021 at 2:22 PM. The UM reported she was leaving work on 12/15/2020 when she heard a loud bang and a NA call out for help. The UM reported when she arrived at Resident #7's room, the bed was tipped over on its side and Resident #7 was on the floor. The UM went on to explain that Resident #7 had hit her head when the bed tipped, and she was transferred to the hospital for evaluation. The UM reported it took 4 staff members to right the bed.

The former Administrator was interviewed on 3/11/2021 at 3:07 PM. The Administrator reported she did not recall ordering a part for the bed to repair it and while she thought the previous MTD had inspected the bed, she was not certain. The Administrator reported that she did not recall if a root cause of the incident was determined.

The former Director of Nursing (DON) was interviewed on 3/12/2021 at 12:59 PM. The former DON reported that she received a phone call on 12/15/2020 to notify her that Resident #7's bed tipped over and Resident #7 fell on the floor. The former DON reported the acting Maintenance Director on 12/15/2020 was a NA who had been filling in the position and the former MTD was available to support him. The former DON reported there were no issues found with the bed and no parts were missing. The former DON reported the facility had daily morning meetings and this incident was discussed with the interdisciplinary team members, but she did not recall the outcome. The former DON noted that

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F 689	Continued From page 36 Resident #7 was able to turn in bed without assistance and one NA frequently would provide care to her in bed. The former DON reported she was not aware the MDS had coded Resident #7 to require 2-person assistance with bed mobility. The Administrator was interviewed on 3/11/2021 at 6:11 PM. The Administrator reported that an investigation should have been conducted into the root cause of the bed tipping over. The Administrator reported because she was not the Administrator at the time, she did not know what had happened regarding the investigation.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and	F 690		4/27/21

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F 690	Continued From page 37 (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and observations the facility failed to ensure 2 of 4 residents, Resident #19 and Resident #36, had medical diagnoses to support an indwelling urinary catheter and physician's orders for indwelling urinary catheters. Findings included: 1. Resident #19 admitted to the facility on 10/29/2019 with diagnoses of diabetes, stroke, and kidney disease. There was not a diagnoses of neuromuscular bladder dysfunction. An Annual Minimum Data Set (MDS) assessment dated 1/23/2021 revealed Resident #19 was moderately cognitively intact and had an indwelling catheter. The Care Plan dated 9/15/2020 stated Resident #19 had an indwelling urinary catheter for neuromuscular bladder dysfunction. A review of the Medication Administration Record and Treatment Administration Record for	F 690	The facility failed to ensure 2 of 4 residents had medical diagnosis to support an indwelling catheter and physician orders for indwelling urinary catheters. Resident #19 catheter was removed on 3/10/21 by hall nurse. Resident #36 catheter was removed on 4/1/21 by hospice nurse. An audit of catheter physician orders and supporting diagnosis was completed by the DON or designee for all residents with catheters on 4/1/21. Any orders identified to need modification were modified by DON on 4/1/21. The staff development coordinator reeducated all licensed nursing staff regarding catheter physician orders and supporting diagnosis on 4/2/21. All newly hired licensed nursing staff will be educated on catheter physician orders and supporting diagnosis by the SDC or designee. Any staff member not in-serviced by 4/2/21 will not be able to work until completion of education.	

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F 690	Continued From page 38 1/1/2021 to 3/11/2021 revealed no documentation of care for Resident #19's urinary catheter. An observation was conducted of Resident #19 on 3/7/2021 at 2:59 pm. Resident #19's catheter bag was hanging from the bed and her urine was dark yellow with a large amount of sediment. Resident #19 stated she did not remember the last time her catheter tubing and bag had been changed. An interview was conducted with Nurse #7 on 3/11/2021 at 8:35 am. Nurse #7 stated she did not see an order on the electronic charting for Resident #19"s catheter or an order to change the catheter. Nurse #7 stated she did not know when Resident #19's catheter or catheter bag should be changed and thought the catheter bag and catheter tubing change should be on the Medication Administration Record (MAR) or the Treatment Administration Record (TAR). Nurse #7 stated she guessed changing the catheter tubing and bag would be at the nurse's judgement. Nurse #7 stated she did not know when Resident #19's catheter bag and tubing had been changed last. The Director of Nursing was interviewed on 3/11/2021 at 9:03 am and stated the facility did not have a physician's order for Resident #19's urinary catheter. She stated Resident #19's urinary catheter should have been removed but the resident kept requesting it and the nurses inserted it again. The Director of Nursing stated the nurse should have asked for a physician's order before reinserting the urinary catheter. The Director of Nursing stated the Nurse should have ensured Resident #19 had a physician's order for the urinary catheter and physician's order to change the urinary catheter monthly and	F 690	The Director of Nursing or designee will review daily orders to ensure physician orders for catheters are implemented accurately and supporting medical diagnosis are in place at the morning meeting. The review will be placed on the physician orders audit form. The Director of Nursing will submit results to the monthly Quality Assurance Performance Improvement Committee meeting for review and need for ongoing monitoring. The person responsible for this plan of correction is the Director of Nursing.	

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F 690	Continued From page 39	F 690		

as needed.

2. Resident #36 was readmitted to the facility after hospitalization on 1/25/21 with an indwelling catheter in place.

A nurse ' s note dated 1/25/21 at 9:45 PM read Resident #36 was readmitted to the facility from the hospital with an indwelling catheter. The note did not indicate a diagnosis for the indwelling catheter.

A progress note dated 1/26/21 by the nurse practitioner indicated Resident #36 had an indwelling catheter but did not include a diagnosis for the catheter.

Resident #36 ' s physician orders for January 2021 did not include an order for the indwelling catheter or an order for care, treatment and changing of the indwelling catheter.

A review of the Medication Administration Record and Treatment Administration Record for January 25, 2021 through March 11, 2021 did not include an order for the indwelling catheter or documentation of care and treatment of the indwelling catheter.

An observation on 3/7/21 at 12:28 PM revealed Resident #36 lying in bed. A catheter drainage bag was observed hanging on the left side of the resident ' s bed. The tubing was observed to have clear, yellow drainage flowing into the bag.

An interview was conducted on 3/9/21 at 2:00 PM with NA #1 who stated she was aware Resident #36 had an indwelling catheter and she cleaned the tubing during care and emptied the bag.

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F 690	Continued From page 40 An interview was conducted on 3/9/21 at 2:15 PM with Nurse #1 who stated she did not know why Resident #36 had an indwelling catheter. She stated orders were put in on admission when a resident is admitted with a catheter. She added the nursing assistants provided care to the catheter. An interview was conducted on 3/9/31 at 2:30 PM with the interim Director of Nursing (DON). She stated she thought Resident #36 had an obstruction and that was the reason for the indwelling catheter. She added there should be orders for the indwelling catheter, orders for care and treatment of the indwelling catheter and orders for changing the indwelling catheter. On 3/12/21 at 9:26 AM, an interview was conducted with the Nurse Practitioner. He stated he thought Resident #36 had neurogenic bladder and that was the reason for the indwelling catheter. After he reviewed Resident #36 ' s medical record, he stated he was unable to locate anything but thought it was an obstruction. He added Resident #36 should have orders for the care and treatment of the indwelling catheter.	F 690		
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	F 727		4/27/21

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F 727	Continued From page 41 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 interview, the facility failed to provide Registered Nurse (RN) coverage for 8 consecutive hours a day for 1 out of 13 days reviewed for staffing (2/25/21). Findings included: A review of the posted Daily Staffing Form Accordius Health at Lexington from 2/24/21 to 3/9/21 revealed the facility did not have Registered Nurse (RN) listed to work in the facility on 2/25/21, 2/26/21, and 3/1/21. A phone interview was completed with Nurse Scheduler (NS) on 3/10/21 at 3:57 PM who stated if we did not have an RN listed then it was the Director of Nursing (DON) who was in the facility to cover for an RN. A phone interview was completed with Nurse Scheduler (NS) on 3/10/21 at 4:26 PM who stated that the Administrator told her that the DON does not count as an RN in the facility. The NS stated that they had a RN working on 2/26/21 and 3/1/21 on the night shift from 6:00 PM to 6:00 AM. The NS confirmed the only day an RN was not scheduled for eight consecutive hours was on 2/25/21. A phone interview was completed with the Director of Nursing (DON) on 3/12/21 at 10:52	F 727	The facility failed to provide registered nurse coverage for 8 consecutive hours a day for 1 out of 13 days. An audit of the daily consecutive 8 hour registered nurse coverage was completed for the month of March by the business office manager or designee. The review indicated that there was not consecutive 8 hour nursing coverage 2 days of the month. The staff development coordinator reeducated the unit managers and scheduler on the requirement for consecutive 8 hour registered nurse coverage in the facility daily on 4/1/21. The Director of Nursing (DON) or designee will review the daily staffing schedule to ensure consecutive 8 hour Registered Nurse Coverage is in place at the morning meeting beginning 4/8/21. Daily staffing postings will be brought to the monthly Quality Assurance Performance Improvement meeting x 3 months for review and need for ongoing monitoring by the DON. The person responsible for this plan of correction is the Director of Nursing.	

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F 727	Continued From page 42 AM who stated that she was not aware of no RN coverage on 2/25/21 but was aware of an agency RN who did work the day shift and would look into it. There was no further follow up from the DON regarding RN coverage on 2/25/21. A phone interview was completed with the Administrator on 3/12/21 at 12:52 PM who stated it is her expectation that the facility follows the Centers for Medicare & Medicaid Services regulatory guidelines.	F 727		
F 732 SS=B	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. (ii) Data must be posted as follows: (A) Clear and readable format.	F 732		4/27/21

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F 732	Continued From page 43 (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 observations, staff interview and review of required posted nurse staffing sheets revealed the facility failed to post accurate nurse staffing information at the beginning of the shift on 2 of 3 survey days and failed to post the actual hours worked by nursing staff for 13 days and document Registered Nurse Coverage on 3 days for nurse staffing information reviewed for 2/24/21 to 3/9/21. Findings included: 1. On 03/7/2021 at 11:42 AM an observation of a form titled "Daily Staffing Form Accordius Health at Lexington" was posted at the front desk in an acrylic sign holder. The date on the form read 3/6/21. The form included the times of the first shift from 6:00 AM to 6:00 PM and second shift 6:00 PM to 6:00AM. On 3/9/21 at 10:03 AM an observation at the front desk of an acrylic sign holder was empty and did not include the "Daily Staffing Form Accordius	F 732	The facility failed to post accurate number of care hours provided by licensed and unlicensed personnel. The Business Office Manager reviewed the daily staffing posting for the month of March for accuracy of care hours against the scheduling system on 4/1/21. The daily posted staffing care hours for licensed and unlicensed staff that were not posted correctly were corrected by the Business Office Manager on 4/1/21. The scheduler and Unit Managers were in-serviced by the Director of Nursing (DON) on posting and updating the daily posted staffing care hours for licensed and unlicensed staff at the beginning of each shift on 4/1/21. Daily staffing sheets will be posted by the scheduler or designee daily at the beginning of each shift.Daily staffing forms will be reviewed at the beginning of each shift to update changes in census and staffing hours by the scheduler or	

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F 732	Continued From page 44 Health at Lexington". 2. A review of the posted Daily Staffing Form Accordius Health of Lexington from 2/24/21 to 3/9/21 revealed the facility did not list the actual hours worked for the Registered Nurses (RN), Licensed Practical Nurses (LPN), Certified Nursing Assistants and Certified Medication Technician. 3. A review of the posted Daily Staffing Form Accordius Health of Lexington from 2/24/21 to 3/9/21 revealed the RN section on the form was blank on 2/25/21, 2/26/21, and 3/1/21. A phone interview was completed with Nurse Scheduler (NS) on 3/10/21 at 4:26 PM who stated she was responsible for giving the Receptionist the schedule who then fills out the Daily Staffing Form. The NS could not explain why the Daily Staffing Form was not posted at the beginning of the shift on 3/7/21 and 3/9/21. The NS stated regarding the RN coverage the Receptionist did not know that a staff who worked the 6:00 PM to 6:00 AM on 2/26/21 and 3/1/21 was an RN and the only day she did not have an RN scheduled was on 2/25/21. A phone interview was completed with the Director of Nursing (DON) on 3/12/21 at 10:52 AM who stated that it was her expectation that posted nurse staffing would follow the state guidelines and be posted daily. The DON stated the NS was responsible for filling out the daily assignment sheets and should fill out the Daily Staffing Form at the same time.	F 732	designee. The DON or designee will review staffing sheets for timeliness of posting and accuracy daily on daily staffing audit form to begin 4/8/21. The DON will submit copies of the daily nurse staffing forms to the Quality Assurance Performance Improvement Committee (QAPI) monthly for three months. The committee will reassess the need for ongoing monitoring as needed. The person responsible for this plan of correction is the Director of Nursing.	
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More	F 759		4/27/21

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F 759	Continued From page 45 CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to maintain a medication error rate of less than 5% as evidenced by a medication error rate of 7.41% (2 errors out of 27 opportunities) (Resident #24). Findings included: a. Resident #24's physician orders were reviewed, and she was prescribed one 80 milligram (mg) furosemide tablet (diuretic medication to help the body evacuate fluids) orally each day in the morning for heart failure and was dated 2/22/20. A medication administration was observed on 3/9/21 at 8:49 AM with Nurse #7. The furosemide 80 mg tablet was not administered to Resident #24. The nurse was not observed dispensing the furosemide 80 mg dose into the medicine cup and the nurse did not provide the bubble pack of the furosemide 80 mg pills to the surveyor for documentation. The count of the medications to which the nurse was going to administer matched the count of the medications which were documented, which did not include the furosemide 80 mg tablet. The electronic Medication Administration Record (eMAR) for Resident #24 was reviewed on	F 759	The facility failed to ensure the medication error rates are not 5 percent or greater as evidenced by 2 errors out of 27 opportunities. On 4/5/2021 the Director of Nursing (DON) notified Resident #24□s physician of medication errors on 3/9/21. The physician did not give a new order. There was no change in the resident□s condition. Nurse #7 is no longer working for the facility. On 4/2/21 the Staff Development Coordinator(SDC) educated all licensed nurses and medication aides. The education covered the 10 Rights of Medication Administration. All newly hired licensed nursing staff and medication aides will be educated on the 10 rights of medication administration by the SDC or designee. Any staff member not in-serviced by 4/2/21 will not be able to work until completion of education. The DON or designee will audit licensed nursing staff and medication aides on medication administration utilizing the Medication Pass Audit Tool. The audit will ensure the medication administration error rate is below five (5) percent. 4 licensed nursing staff and medication aides will be audited weekly x4 weeks, then 2 weekly x	

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F 759	Continued From page 46 3/11/21 at 1:30 PM and furosemide 80 mg tablet was documented as having been administered at 9:00 AM on 3/9/21 by Nurse #7. Nurse #7 was interviewed on 3/11/19 at 1:43 PM. She stated she believed she had administered the furosemide 80 mg tablet to Resident #24. The nurse went to the cart and pulled the medication card from the cart and showed the medication was in the cart and she reiterated she believed she had administered the furosemide to the resident. The nurse stated she remembered counting through the medications which were to be administered to the resident on 3/9/21 and could not explain as to how the medication count could not have included the furosemide. b. Resident #24's physician orders were reviewed, and she was prescribed two 10 mg omeprazole capsules (medication to decrease acid reflux and heartburn) orally each day for Gastro Esophageal Reflux Disease (GERD) and was dated 2/22/20. A medication administration was observed on 3/9/21 at 8:49 AM with Nurse #7. One capsule of 10 mg omeprazole, totaling 10 mg, was administered to Resident #24. The eMAR was reviewed on 3/11/21 at 1:30 PM and two 10 mg omeprazole capsules were documented as having been administered at 9:00 AM on 3/9/21 by Nurse #7. Nurse #7 was interviewed on 3/11/19 at 1:43 PM. She stated she believed she had administered one 20 mg omeprazole capsule to Resident #24. The nurse went to the cart and pulled the medication card from the tablet and she stated	F 759	2 months by the DON or designee beginning 4/8/21. The DON or designee will immediately address all areas of concern. The DON or designee will present the findings and trends of the Medication Pass Audit Tool to the Quality Assurance and Performance Improvement (QAPI) committee monthly for 3 months. Any issues, concerns, and/or trends identified will be addressed by implementing changes as necessary, to include continued frequency of monitoring. The DON is responsible for implementing this plan of correction.	

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F 759	Continued From page 47 what she thought was a 20 mg omeprazole capsule was actually a 10 mg omeprazole tablet. She said she had not administered the correct dose of 20 mg of omeprazole and had only administered 10 mg of omeprazole on 3/9/21. The nurse stated that because she had thought it was a 20 mg capsule of omeprazole, she had only administered one, thinking it was a 20 mg capsule, and it would have been the correct dose. The Director of Nursing (DON) was interviewed during a phone interview on 3/12/21 at 1:48 PM. She stated it was her expectation for the nurses to administer the medications as ordered. The Administrator was interviewed during a phone interview on 3/12/21 at 1:48 PM and she stated it was her expectation for the nurses to follow Centers for Medicare and Medicaid Services (CMS) guidelines for medication administration. A phone interview was conducted with the Adult Geriatric Nurse Practitioner (AGNP) on 3/18/21 at 3:09 PM. He stated it was his expectation for the medications which were ordered by himself or other health care providers to be administered as ordered. He said he did not believe Resident #24 would have suffered any negative impacts from having only received 10 mg of a 20 mg dose of omeprazole and having missed a one day dosing of the 80 mg furosemide tablet.	F 759		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 761		4/27/21

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F 761	Continued From page 48 professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to maintain a medication refrigerator within the recommended temperature range for 2 of 2 medication refrigerators (A-side and B-side), failed to maintain daily medication refrigerator temperature log documentation for 2 of 2 medication refrigerators (A-side and B-side) and failed to dispose of expired medications discovered in 1 of 1 medication storage rooms (B-side). Findings included: A review of the facility's Medication Storage policy dated 11/01/20 indicated all medications would be	F 761	The facility failed to maintain a medication refrigerator within the recommended temperature range for 2 of 2 medication refrigerators. The facility failed to maintain daily temperature log documentation and failed to dispose of expired medications. On 3/7/21 nurse #3 discarded the identified influenza virus vaccine-11 packs with 10 vials each and Tuberculin purified protein derivative 2- vials. On 3/11/21 the unit manager discarded the identified influenza virus vaccine 16 syringes and tuberculin purified protein derivative- 2 vials. On 3/7/21 nurse #3 discarded the	

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F 761	Continued From page 49 stored based on the manufacturer's recommendation and ...the refrigerator temperatures were to be maintained 36-46° Fahrenheit (°F). Charts were to be kept on each refrigerator and temperature levels were to be recorded daily. In the event a refrigerator was malfunctioning, the person discovering the malfunction must promptly report such finding to the Maintenance Department for emergency repair. 1. On 03/07/21 at 11:41 AM a review of the B-side medication refrigerator was conducted with Nurse #3 in attendance. The B-side medication refrigerator temperature was observed to be 28°F and verified with Nurse #3. The following medications were in the B-side refrigerator that required a storage temperature of 36-46°F per the medication packaging and were not to be frozen: 1. Influenza Virus Vaccine-11packs with 10 vials each 2. Tuberculin Purified Protein Dirivative-2 vials. Review of the February 2021 refrigerator temperature log revealed no temperatures were documented for February 10, 13, 14, 15, 16, 26, 27, 28. No temperature log was discovered for March 2021. The instructions at the bottom of the Refrigerator log read: "the temperature should be less or equal to 41°F and optimal refrigerator temperature was 33-38°F. Contact your supervisor for temperatures outside this range." Nurse #3 was interviewed on 03/07/21 at 11:50 AM about the medication refrigerator being below the recommended temperature range. She stated that there was a back-up refrigerator that could	F 761	identified saline enemas. On 4/1/21 the unit manager documented the medication refrigerator temperatures on the temperature log for A and B side medication refrigerators. The medication carts and medication storage closets were audited on 4/1/21 by the DON or designee to ensure medications are stored, dated, and discarded as required. The medication storage refrigerators were audited on 4/1/21 by the DON or designee to ensure medications are stored between 36-46 degrees F and temperatures are logged on the temperature log. The Licensed Nurses and Medication Aides were reeducated on 4/2/21 by the staff development coordinator or designee related to ensuring medications are stored, dated, and discarded as required. The Licensed Nurses and Medication aides were re-educated on reviewing medication refrigerator temperatures, logging the temperature on the temperature log and notification to the DON if temperature is outside of the recommended temperature ranges. All newly hired licensed nursing staff and medication aides will be educated on ensuring medications are stored, dated, and discarded as required, reviewing medication refrigerator temperatures, logging the temperature on the temperature log and notification to the DON if temperature is outside of recommended temperature ranges and during orientation by the SDC or designee. Any staff member not in-serviced by 4/2/21 will not be able to	

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F 761	Continued From page 50 be utilized. She said the refrigerator temperature was to be checked on night shift. A phone interview with the facility's consulting Pharmacist was conducted on 03/11/21 at 1:40 PM regarding medication refrigerator storage. She stated the medication refrigerators should be checked daily. She said the refrigerated medications should be stored at the manufacturer's recommended temperatures and not below freezing. The Director of Nursing (DON) was interviewed on 3/11/21 4:07 PM regarding medication storage. She stated she would expect the medications to be stored within the manufacturer recommended temperature range, the temperature logs to be completed and out of range temperatures to be reported. 2. On 3/11/21 at 3:20 PM a review of the A-side medication refrigerator was conducted with the Unit Manager in attendance. The A-side medication refrigerator temperature for 3/11/21 was recorded on the temperature log to be 38°F. The Temperature logs for February and March 2021 ware reviewed for A-side and revealed no temperatures were documented on February 3, 4, 8, 9, 12 or 13. Temperatures documented on February 2 was 30°F, February 5, 6, and 11 were noted to be 32°F and March 3 at 32°F. The instructions at the bottom of the Refrigerator log read: "the temperature should be less or equal to 41°F and optimal refrigerator temperature was 33-38°F. Contact your supervisor for temperatures outside this range." The following medications were in the A-side	F 761	work until completion of education. The DON or designee will complete an audit weekly x 3 months to ensure medications continue to be stored, dated, and discarded as required and the medication refrigerator log is completed and within recommended temperature ranges. The Director of Nursing or designee will submit a report to the Quality Assurance Committee monthly for 3 months. The Director of Nursing is responsible for monitoring and follow up.	

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F 761	Continued From page 51	F 761		

refrigerator that required a storage temperature of 36-46°F per the medication packaging and were not to be frozen:
1. Influenza Virus Vaccine 16 syringes
2. Tuberculin Purified Protein Dirivative-2 vials.

An interview was completed with the Unit Manager on 03/11/21 at 12:55 PM regarding the refrigerator temperature logs and medication storage. She stated if the temperature was low on the refrigerator, they should have spoken with maintenance to fix it and they should have communicated with pharmacy to see if any medications in the refrigerator were not safe to administer.

A phone interview with the facility's consulting Pharmacist was conducted on 03/11/21 at 1:40PM regarding medication refrigerator storage. She stated the medication refrigerators should be checked daily. She said the refrigerated medications should be stored at the manufacturer's recommended temperatures and not below freezing.

The Director of Nursing (DON) was interviewed on 3/11/21 4:07 PM regarding medication storage. She stated she would expect the medications to be stored within the manufacturer recommended temperature range, the temperature logs to be completed and out of range temperatures to be reported.

3. An inspection of the medications kept in the B-side medication storage room was conducted on 03/07/21 at 11:41 AM with Nurse #3 in attendance. Two expired saline enemas were identified with an expiration date of 01/2021.

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F 761	Continued From page 52 An interview was done with Nurse #3 on 03/07/21 at 11:50 AM regarding the expired medications. She stated they rotated the medications and put the medications with the closest expiration dates to the front of the cabinet. She explained that expired medications should not be in the cabinets. The DON was interviewed on 3/11/21 4:07 PM regarding medication storage. She stated she would expect the medications kept in the storage room to not be expired.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and record review, the facility failed to remove	F 812	The facility failed to remove outdated, unlabeled food items stored in 1 of 2	4/27/21

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F 812	Continued From page 53 outdated, unlabeled food items stored in 1 of 2 nourishment rooms. This practice had the potential to affect residents on the 400, 500 and 600 Halls. The findings included: On 03/07/21 at 11:05 AM an initial tour of the kitchen was made with the Dietary Manager (DM). The initial tour included observations of the facility's nourishment rooms. The DM reported the nourishment rooms were used to store perishable and non-perishable food items for residents. On 03/07/21 at 11:30 AM the 400, 500 and 600 Halls' nourishment room was observed with the DM. The contents inside the refrigerator included four disposable containers stored ready for use. Three of the 4 disposable containers were not labeled or dated. The DM opened the containers revealing partially consumed food. One of 4 containers was dated 02/22/21. The DM removed the four food containers and placed them in the trash. During this observation, the DM referenced a sign, taped to the outside of the refrigerator, instructing staff to label and date food items and leftover food was to be stored for 3 days. The DM reported the nourishment refrigerators were checked daily by dietary staff who were trained to audit the contents of the refrigerators and remove all unlabeled and/or outdated food items stored. The DM stated perishable food items were good for three days.	F 812	nourishment rooms. The Dietary Manager removed the four food containers identified on 3/7/21. The Director of Dining Services completed an audit of all nourishment room refrigerators on 3/29/21. All items were properly stored, dated and labeled. No items were identified as out of date. All staff were re-educated on labeling and dating of food items to be stored in resident nourishment rooms by the staff development coordinator or designee on 4/2/21. All newly hired staff will education on labeling and dating of food items to be stored in resident nourishment room by the staff development coordinator or designee. Any staff member not in-serviced by 4/2/21 will not be able to work until completion of education. The Dietary Manager or designee will complete daily checks of the nourishment room refrigerators to ensure items placed in the refrigerator are properly stored, dated, and labeled for four weeks, then weekly for 2 months. Audits of nourishment rooms will be submitted y the Dietary Manager to the Quality Assurance Committee (QAPI) monthly x 3 months to ensure proper compliance and will reassess the need for ongoing monitoring. The person responsible for this plan of correction is the Dietary Manager.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		4/27/21

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F 880	Continued From page 54 §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:	F 880		

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F 880	Continued From page 55 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interviews with facility staff the facility failed to follow the Centers for Disease Control (CDC) guidelines for Personal Protective Equipment (PPE) for Transmission Based Precautions (Nurse #1, NA #3) and maintain an infection control program. This occurred when Nurse #1 failed to perform hand hygiene, wear eye protection and a gown when entering Resident #118's room and when NA #3 failed to don protective eyewear prior to entering Resident	F 880	The facility failed to maintain an infection control program and follow CDC guidelines for PPE and Handwashing. Resident #118 discharged from facility on 3/23/21. On 4/1/21 the Director of Nursing (DON) reviewed 100% of residents that met criteria for enhanced droplet precautions. All residents requiring enhanced droplet precautions (EDP) had the correct signage posted on door and PPE was	

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F 880	Continued From page 56 #118's room, who was on Enhanced Droplet Precautions. The facility also failed to post Enhanced Droplet Precaution signs on 2 out of 3 new admissions reviewed for Enhanced Droplet Precautions. In addition, the facility failed to bag soiled linen and trash at the point of collection for 1 of 6 halls observed and failed to store soiled linen and trash in collection bins for 2 of 6 halls observed. Findings included: The facility policy for Isolation-Categories of Transmission-Based Precautions revised on 03/01/20, stated that for COVID-19 or Persons Under Investigation (PUI), Enhanced Droplet Precautions signage would be used and mask, gown and eye protection should be worn. The CDC guidelines for Enhanced Droplet Precautions revised 02/26/21 indicated that healthcare workers should wear a surgical or medical mask, wear eye protection, gown and gloves. Resident #118 was admitted to the facility on 03/05/21 from the hospital. Review of the medical record indicated the resident was cognitively intact on the admission history and physical completed on 03/07/21. Record review of the Physician Assistant's admission note indicated Resident #118 was a new admission from the hospital on 03/05/21. He was placed in a 14-day quarantine per CDC guidelines with Enhanced Droplet Precautions. Review of the Covid19 test laboratory report indicated Resident #118's test completed on 03/09/21 was confirmed positive on 03/11/21.	F 880	available on hallway. On 4/1/21 the DON completed 100% infection control audit in the building on PPE, Trash and Linen. Upon review staff wore PPE correctly upon entrance and exit of enhanced droplet precaution rooms, hand hygiene was performed prior to resident care, trash was bagged at point of collection and trash was properly stored in bins on hallway. On 4/2/21 the Staff Development Coordinator (SDC) or designee re-educated all staff on PPE required for enhanced droplet precautions, hand hygiene, posting of enhanced droplet precaution signage for new admissions that meet criteria for enhanced droplet precautions, bagging soiled linen and trash at the point of collection and storing linen and trash in collection bins on hallway. All newly hired staff will be in-serviced on PPE required for enhanced droplet precautions, hand hygiene, posting of enhanced droplet precaution signage for new admissions that meet criteria for enhanced droplet precautions, bagging soiled linen and trash at the point of collection and storing linen and trash in collection bins on hallway by Staff Development Coordinator (SDC) or designee. Any staff member not in-serviced on 4/2/21 will not be able to work until education is complete. The Director of Nursing or designee will audit 10 staff members using the infection control audit tool x 8 weeks, then 10 monthly for one month to ensure correct EDP signage, proper PPE utilization and availability, handwashing, proper management of soiled linen and trash	

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F 880	Continued From page 57 a. An observation was conducted on 03/07/21 at 11:15 AM of Resident #118 resting in bed watching TV. There was an Enhanced Droplet Precaution sign on his door. The sign indicated gloves, gown, mask and eye protection should be worn. No PPE supplies were located outside his room, gloves were inside the room. b. An observation was conducted on 03/07/21 at 11:25 AM of Nurse #2 entering Resident #118's room to administer medications. She had drawn up the medications, locked the cart and donned gloves without sanitizing her hands and had a mask on covering her mouth and nose. She failed to put a gown on or eye protection per the instructions on the Enhanced Droplet Precaution sign posted on the door. c. An observation on 03/07/21 at 11:30 AM of Nurse #2 was completed as she went into Resident #118's room preparing to do a blood glucose test. The nurse donned gloves without sanitizing her hands and had a mask on covering her mouth and nose. She failed to put a gown or eye protection on per the instructions on the door for Enhanced Droplet Precautions. An interview was done on 03/07/21 at 11:30 AM with Nurse #2 and she was asked about the sign for Enhanced Droplet Precautions on the door. The nurse stated "I don't know and to be honest they would have told me if he was in isolation and there would be a cart here with the Personal Protective Equipment (PPE) supplies. When asked about not wearing the designated PPE she said, "I need to check as maybe they forgot to take the sign down but I am not for sure." She was also asked about hand hygiene and she	F 880	beginning 4/8/21. Audits of infection control audit tool will be submitted by the Director of Nursing or designee to the Quality Assurance Committee (QAPI) monthly x 3 months to ensure proper compliance and will reassess the need for ongoing monitoring as needed. The Director of Nursing is responsible for this plan of correction.	

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noted she had washed her hands before she went to the medication cart to get the medications and blood glucose meter out. She stated, "I don't do hand hygiene between taking medication out of the cart and going into the resident's room."

An interview with Nurse #2 was done on 03/07/21 at 12:03 PM regarding quarantined residents and she stated that the new admissions were in isolation for 14 days with Enhanced Droplet Precautions.

Nurse #2 was interviewed via phone on 03/09/21 at 5:11 PM about the facility's isolation protocols and Resident #118 Enhanced Droplet precautions. She stated she had not received any information in report that he was a new admission and she thought the sign had not been taken down from when it had been a COVID unit.

The Infection Prevention Nurse was interviewed on 03/11/21 at 3:21 PM. She stated the protocol for new admissions was that Enhanced Droplet Precautions (EDP) were followed for 14 days and there should be communication of the new admission or the reason for isolation at change of shift. She said education about infection prevention was located in binders on the units. She noted with EDP they were to don the appropriate PPE beforehand which included a gown, face shield or goggles, mask and gloves. She noted they should wash or sanitize before donning gloves.

An interview with the Unit Manager was done on 03/11/21 at 12:55 PM regarding the facility's Transmission Based Precautions. It was stated that all admissions were placed on a 14-day quarantine and Enhanced Droplet Precautions.

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She noted education on the Infection Control policies had been done with facility and agency staff. She said all nurses should be aware of new admission protocols and proper hand hygiene.

An interview with the Director of Nursing (DON) was conducted on 03/11/21 at 3:43 PM about staff education. She stated education was done for agency staff that came to the facility and there were Infection Control binders for reference at the nursing stations. The DON said all staff should be wearing the eye protection, gown, mask and gloves and this was standard with all admissions.

The Administrator and Regional Consultant #1 were interviewed on 03/11/21 at 4:28 PM regarding the Infection Control policies for hand hygiene and new admissions. The Administrator noted the facility followed the facility COVID 19 plan and CDC guidelines and monitored for signs and symptoms of COVID, utilized Enhanced Droplet Precautions, a 14-day quarantine for new admissions and performed the routine Centers for Medicare and Medicaid (CMS) testing. She said proper PPE and hand hygiene were important.

d. On 03/07/21 at 12:20 AM Resident #118 was observed in his private room with a sign alerting staff of enhanced droplet isolation precautions. There was a 3-drawer plastic storage bin filled with personal protective equipment (PPE) next to the door of the room.

On 03/07/21 at 12:24 PM observations of the lunch meal were made on the 100 Hall. During the observation, nurse aide (NA) #3 was in Resident #118's room assisting the resident with

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a milk carton. NA#3 was noted to have on gloves, a gown, a face mask but no protective eyewear. The NA removed and discarded all PPE prior to exiting the room and performed hand hygiene using alcohol-based hand sanitizer.

On 03/07/21 at 12:28 PM NA #3 was interviewed and reported she was trained to wear a face mask, gloves, protective eyewear, and disposable gown each time she entered a room on enhanced droplet precautions. NA #3 acknowledged she did not wear protective eyewear when she entered Resident #118's room and offered no explanation for failing to do so.

On 03/09/21 at 5:21 PM the facility's Regional Director of Clinical Services assigned to Infection Prevention was interviewed and explained all staff, including agency staff, had been trained and expected to wear all necessary personal protective equipment when entering a resident's room on enhanced droplet isolation. She stated that protective eyewear was required by staff when assisting a resident on enhanced droplet isolation.

Findings included:

e. A review of the facility policy, revised on 3/1/20 titled, Isolation-Categories of Transmission-Based Precautions, revealed under Airborne Precautions 8. Signs-The facility will implement a system to alert staff to the type of precaution resident requires. a. This facility utilizes the following system for identification of Airborne Precautions with appropriate signage. Under Droplet Precautions 9. Signs-The facility will implement a

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system to alert staff and visitors to the type of precaution the resident requires. a. Enhance droplet signage used for COVID-19 or Patient Under Investigation (PUI). 10. This facility utilizes the following system for identification of Droplet Precautions appropriate signage.

The Centers for Disease Control (CDC) guidelines for new admissions or readmissions to a nursing home, dated 4/30/20, indicated newly admitted or readmitted residents should still be monitored for evidence of COVID-19 for 14 days after admission and cared for using all recommended COVID-19 Personal Protective Equipment (PPE).

A review of the facility policy, implemented on 11/1/20 titled, Infection Prevention and Control Program, revealed under 11. c. Isolation signs are used to alert staff, family members, and visitors of isolation precautions.

A review of the facility COVID plan, updated December 2020, titled, Accordius Health Lexington North Carolina COVID Plan, revealed the type of transmission-based precautions will be communicated by the signage on the door of the resident's room in both quarantine and isolation.

Resident #270 was admitted on 2/26/21 from an acute care facility and was to be placed on 14-day quarantine with enhanced droplet precautions as part of being a new admission to the facility.

During an observation of the room of Resident #270 conducted on 3/7/21 at 11:38 AM, there was no signage on the door of the resident for

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Enhanced Droplet Precautions. Further observation in the hallway outside the door of Resident #270 revealed no PPE for Resident #270 and no PPE available for use in the hallway at other rooms near Resident #270's room.

An observation conducted on 3/7/21 at 12:14 PM revealed Nurse #9 to have placed a storage container with drawers and PPE outside of the neighboring room for Resident #270, but no PPE outside of the room for Resident #270.

An observation on 3/7/21 at 12:40 PM revealed Resident #270 had an Enhanced Droplet Precaution signage on the room door. Resident #270's room door was closed and there was a storage container with drawers and PPE located outside of the neighboring room, but not a storage container with PPE located outside of Resident #270's room.

An interview was conducted with Nurse #2 on 3/7/21 at 1:59 PM. She said she thought COVID was over and they had opened the hallways back up regarding residents who had been placed on Enhanced Droplet Precautions for the residents on the hallway of Resident #270.

During an interview with the Director of Nursing (DON) on 3/10/21 at 10:35 AM she stated residents who were new admissions to the facility were to be placed on Enhanced Droplet Precautions for 14 days after their admit date. She said Resident #270 did not have signage on her door the morning of 3/7/21 nor was there PPE available in the hallway to be worn into the room of Resident #270. She said the signage regarding Enhanced Droplet Precautions was placed on the door of Resident #270 at lunch time

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on 3/7/21 as well as the storage container with drawers of PPE was placed outside of the neighboring room for use for Resident #270 and other residents on the hall who were on Enhanced Droplet Precautions. She further explained Resident #270 was admitted on 2/26/21 from the hospital and needed to be on Enhance Droplet Precautions until 3/12/21, a total of 14 days.

An interview was conducted with Regional Nurse Consultant #2 on 3/11/21 at 3:43 PM. She stated Resident #270 did not have a sign on her door for Enhanced Droplet Precautions, PPE was not available on the hall Resident #270 was residing on, and there was not a disposal receptacle for used PPE in the room of Resident #270. She explained Resident #270 was admitted to the facility from a hospital on 2/26/21 and as of 3/7/21, she should still have been on Enhanced Droplet Precautions due to having been admitted to the facility less than 14 days ago. She further stated there should have been signage on the door of the room for Resident #270, there should have been PPE available either at the door of the room for Resident #270, or at least in the same hallway in close proximity to Resident 270's room. She said she believed there was a focus on another hallway having been the new admit quarantine hall and staff members had not thought of the hall where Resident #270 resided as a hall where residents were on quarantine.

During a phone interview conducted on 3/12/21 at 1:48 PM the Administrator stated the facility followed CDC guidelines.

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f. The 600 hall was observed on 3/9/2021 at 9:30 PM. Two bins, one labeled "trash" and one labeled "linen" were noted to sit at the top of the hall by room 601. Two trash bags were noted to be sitting on the floor between room 605 and 607. One bag appeared to have soiled linen and the other bag appeared to have soiled disposable briefs and trash.

Nursing assistant (NA) #4 was observed on 3/9/2021 at 9:45 PM exiting room 608 with an unbagged soiled incontinence brief in one hand and unbagged, soiled linen in his other hand. NA #4 was carrying an incontinence brief with the fecal contents exposed. As NA #4 walked out of room 608 and into the hall, he wrapped the soiled incontinence brief on itself to contain fecal matter. NA #4 was observed placing the soiled brief in one bag on the floor and the linen into the other bag on the floor.

NA #4 was interviewed on 3/9/2021 at 9:45 PM. NA #4 reported he was unable to obtain soiled linen or trash bins at the start of his shift and he was using the trash bags on the floor. When asked about the bins at the top of the 600 hall, NA #4 reported those bins were NA #5's, and because she was working the 400, 500 and 600 halls, she took the bins with her. NA #4 reported

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he was aware that placing the bags on the floor with the soiled linen and trash was an infection control issue, but he was busy and trying to get his resident care completed. NA #4 was unable to explain why he had not placed the soiled brief or linens in a bag inside room 608 to transport out in the hall. NA #4 reported he had been instructed to place all trash and soiled linen in a trash bag for transport to the trash and linen bins, but he felt that took time away from resident care.

g. The 500 hall was observed on 3/9/2021 at 9:48 PM. A bin labeled "trash" was sitting in the hall in between room 506 and 508. A trash bag was tied to the handle of the bin and sitting on the floor. The bag was filled with soiled linen.

NA #6 was interviewed on 3/9/2021 at 9:48 PM. NA #6 reported she was unable to get a second bin for the soiled laundry and she used a bag tied to the trash bin. NA #6 reported there was only one bin on the back hall by the exit when she started her shift at 6:00 PM. NA #6 reported she was aware that setting the soiled linen bag on the floor was an infection control issue.

The charge nurse was interviewed on 3/9/2021 at 9:56 PM. The charge nurse reported she was not aware NA #5 or NA #6 were unable to find bins for their halls. The charge nurse reported there should be 2 bins for each hall, for a total of 6 bins. The charge nurse further explained that trash and linen should be bagged at the point of collection, or in the resident room before transported to the laundry or trash bin.

An interview was conducted with NA #7 on 3/9/2021 at 10:15 PM. NA #7 reported the bins were stored on the back hall by the exit and there

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were no more bins available. NA #7 explained the back hall connected the 400 hall and the 300 hall and was located by an exit door to the dumpsters and the laundry room. NA #7 reported the NA staff took all bins to the back hall at the end of their shift and delivered the soiled laundry to the laundry room and took the bagged trash out of the bin for disposal in the dumpster. NA #7 stated that the bins were left on the back hallway for the next shift to get for their shift.

NA #5 was interviewed on 3/9/2021 at 10:22 PM. NA #5 reported she was working all halls on Unit B and she used the bins that were on the hall to dispose of her soiled linen and trash. NA #5 reported the bins were stored on the back hall. NA #5 reported she did not take the bins off the halls with her when she went to another hall to work.

The Director of Nursing (DON) was interviewed on 3/10/2021 at 11:35 AM. The DON reported she was not certain why NA #5 and NA #6 were not able to find bins for soiled linen and trash storage. The DON reported the NAs should bag trash and soiled linen in a resident's room and take it to the bin on the hall. Once the shift is finished, each NA was responsible for taking the bins to the back hall to deliver the soiled linen to the laundry room and take the trash outside to the dumpster. The DON reported it was her expectation staff bagged soiled linen and trash at the point of collection, transported soiled linen and trash in individual trash bags out in the hall and stored the soiled linen and trash in the bins.

The Administrator was interviewed on 3/9/2021 at 10:26 PM. The Administrator reported the facility had plenty of bins for the storage of soiled linen

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F 880	Continued From page 67 and trash and the NAs should have bins available for every hall in the facility. The Administrator reported she expected the staff to bag the trash and soiled linen at the point of collection, transport soiled linen and trash in an individual trash bags for storage in the bins on the hall until the end of their shift.	F 880		