STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345080	A. BUILDING _____ B. WING _____	C 03/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB HICKORY VIEWMONT	220 13TH AVENUE PLACE NW HICKORY, NC 28601

(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 on 03/22/21 through 03/25/21. The facility was found in compliance with the requirement FR 483.73, Emergency Preparedness. Event ID #O73011.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 03/22/21 through 03/25/21. Event ID# O73O11 6 of the 26 complaint allegations were substantiated resulting in deficiencies.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff and Resident interviews, the facility failed to assess Resident #65's ability to self-administer an inhaler which was left at the Resident's bedside. This was for 1 of 1 resident reviewed for self-administration of medications. The finding included: Resident #65 was admitted to the facility on 05/17/20 with diagnoses that included Chronic Obstructive Pulmonary Disease (asthma). The quarterly Minimum Data Set (MDS) assessment dated 02/25/21 revealed, Resident	F 554	Preparation submission and implementation of this plan of correction does no constitute an admission of or agreement with the facts and conclusions set fourth on the survey report. Our plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. Resident #65 assessment and care plan was completed. Resident #65 was unable to comply with requirements for self administration of medication. Medications	4/23/21

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

Electronically Signed | 04/19/2021

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F 554	Continued From page 1 #65 had intact cognition and had adequate hearing and vision. The MDS also indicated, the Resident had clear speech. A review of Resident #65's medical record revealed no care plan for self-administration of medications. A review of Resident #65's medical record revealed no assessment for Self-administration of Medication Review. A review of Resident #65's Physician order and Medication Administration Record (MAR) dated March 2021 revealed an order dated 06/22/20 for Ventolin HFA (hydrofluoroalkane) (a medication used to treat asthma) Aerosol Solution 108 MCG (micrograms), inhale 2 puffs orally every 4 hours as needed for dyspnea (difficulty breathing), use with spacer. There was no order for the inhaler to be left at bedside or for the Resident to self-administer the inhaler. The MAR also revealed no documentation that Resident #65 had received an administration of the Ventolin inhaler. On 03/22/21 at 10:56 AM an interview and observation was made of a Ventolin inhaler on Resident #65's over bed table. The Resident explained, that he used the inhaler for his asthma which he has had since he was 8 years old. On 03/23/21 at 2:20 PM an observation was made of the Ventolin inhaler on Resident #65's over bed table. The Resident was not in the room. On 03/24/21 at 9:15 AM an observation was made of the Ventolin inhaler on Resident #65's	F 554	removed from bedside. All residents have the potential to be effected. All residents were assessed and no additional issues were identified. The Director of Nursing / Designee conducted an in-service to all nursing staff on medication self-administration policy including to report any type of medications that are at bed side. All nursing / agency staff educated on removing medications in the room if found. All residents will be assessed upon admission readmission, quarterly and annually to determine the desire to self-administer medications. Residents that want to self administer medications, an assessment will be done to verify if they qualify to self administer. An order will be obtained, the medications will be locked at bedside and the resident will document usage of medications. The Director of Nursing / Designee will conduct weekly audits for (3) three residents a week times (4) weeks, (2) two residents a week times (4)weeks, (1) resident a week times (4)weeks to assess for medications at the bedside. The Director of Nursing / Designee Nurse will report results of the audits in the facility's monthly QAPI meetings.	

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F 554	Continued From page 2	F 554		

over bed table. The Resident explained, that for about 4-5 months the nurses have allowed him to keep the inhaler in his room because he sometimes needed the inhaler in a hurry and could not wait on the nurses to get the inhaler when he needed it. The Resident stated, he used the inhaler about once every other day for shortness of breath related to his asthma.

On 03/25/21 at 9:49 AM an observation was made of the Ventolin inhaler on Resident #65's over bed table.

An interview was conducted on 03/25/21 at 11:48 AM with Nurse #3 who worked on 03/23/21, 03/24/21 and 03/25/21 on Resident #65's hall. The Nurse stated, she was not aware of Resident #65 or any resident being able to self-medicate. She explained, that for the resident to be able to self-medicate they would have to have a physician's order and would have to be assessed as being able to mentally and physically be able to self-medicate. The Nurse had no explanation as to why the Ventolin inhaler was left at Resident #65's bedside.

During an interview with Nurse #2 on 03/25/21 at 2:46 PM she confirmed, she worked with Resident #65 on 03/22/21. The Nurse stated, she was unaware of Resident #65 or any other resident keeping medications at their bedside. She continued to explain, that the facility's policy for residents to be able to keep medications at bedside and self-medicate was that they had to have a physician's order to keep the medication at bedside and self-medicate, they had to be assessed as being mentally and physically be able to self-administer the medication and the medication had to be in a locked box for safety

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F 554	Continued From page 3 purposes. The Nurse also added the resident had to be care planned to be able to self-medicate. On 03/25/21 at 11:51 PM during an interview with MDS Nurse #2 she explained, that she was not aware that Resident #65 kept his Ventolin inhaler at his bedside. The Nurse continued to explain that in order for the residents to keep their medication at bedside they had to have a specific order for the medication to be kept at bedside and they had to be assessed as being mentally and physically able to administer the medication kept at their bedside. The MDS Nurse also explained that the resident had to be care planned for self-administration of the medication. An interview was conducted with the Director of Nursing (DON) on 03/25/21 at 4:43 PM. The DON stated that she was unaware that Resident #65 kept his Ventolin inhaler and explained that in order for Resident #65 to keep the medication at his bedside side, the resident would have to be assessed to be able to medicate himself safely and they would have to obtain a physician's order to keep the medication at his bedside. The DON also added the facility would have to develop a care plan to address the Resident's self-medication and for the medication to be left at bedside.	F 554		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.	F 558		4/23/21

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F 558	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on record review, observation, resident interview and staff interviews, the facility failed to provide access to control the light fixture behind the bed for 1 of 1 resident reviewed for accommodate of needs (Resident #35). The findings included: Resident #35 was admitted to the facility on 04/12/19 with diagnoses included diabetes mellitus, end-stage renal disease, and unsteadiness on feet. Review of the quarterly Minimum Data Set (MDS) dated 02/01/21 assessed Resident #35 with intact cognition and impaired vision. Resident #35 needed limited assistance with 1-person physical assist for transfers. The MDS further indicated activity of walking in the room or in the corridor did not occur during the 7-day period. Review of the Care Area Assessment dated 01/14/21 revealed Resident #35 was non ambulatory, able to see only large prints, and at risk for Activities of Daily Living (ADL) decline and falls. Review of care plans revealed Resident #35 was at risk of ADL self-care performance deficit and falls. The goals were to improve from current level of function and minimize risk of falling. Interventions included anticipated and met all needs in a timely manner, encouraged utilization of call light to ask for assistance, and provided a safe environment with personal items within reach.	F 558	Preparation submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set fourth on the survey report. Our plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. The Maintenance Director / Designee replaced the string attached to the light fixture behind the bed for resident #35 on 3/25/21. All residents have the potential to be affected. All light fixtures behind the bed have a string, so that the light can be turned on. No additional issues were identified. All fixture strings to the light fixture behind the bed will not be tied to the bed handrails to prevent the strings from breaking. All light fixture strings will be completed behind the bed by 4/23/21. The Maintenance Director / Designee will re-educate staff on all shifts to report any types of maintenance repair (including light fixture strings) in the maintenance book located at the nursing station. The Maintenance Director / Designee will conduct weekly environmental audits to ensure building and equipment is in good condition and adaptive equipment available for (5) five rooms a week times	

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F 558	Continued From page 5 Review of Resident # 35's medical records revealed she had moved to her current room since 12/15/20. During an observation conducted on 03/22/21 at 10:23 AM, the string attached to the light fixture behind Resident #35's bed to control the light was broken. It extended approximately 2.5 inches from the light fixture and approximately 60 inches above the floor. The room did not have adequate lighting as the light was not switched on during observation. During an interview with Resident #35 on 03/24/21 at 10:22 AM she stated the string attached to the light fixture had been broken since the first day she moved to the room. She could not stand up to reach the string to pull on or off the light according to her preferences. She had been totally dependent on the staff to control the light fixture in the past 3 months. It was very inconvenient to her and she was frustrated why none of the staff would do something to fix the problem. During an interview with Nurse #7 on 03/24/21 at 11:16 AM she stated she had provided care for Resident #35 in the past 3 weeks. She did not notice that the string that used to control the light fixture behind the bed was broken. During an interview with the Maintenance Director on 03/24/21 at 11:21 AM he stated he rounded the facility at least 3 times per week. He indicated it was his oversight to miss the broken string, causing Resident #35 unable to reach the string to control the light fixture. He would fix the problem as soon as possible.	F 558	(4)weeks, (4)four rooms a week times (4)weeks, (3)three rooms a week times (4)weeks. The Maintenance Director / Designee will report results of the audits in the facility's monthly QAPI meetings.	

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F 558	Continued From page 6 During an interview with the Administrator on 03/25/21 at 2:31 PM he stated it was his expectation for all the light fixtures to be in good repair in order to accommodate residents' needs and preferences. During a phone interview with the Director of Nursing on 03/25/21 at 5:01 PM she stated it was her expectation for all the residents to have full access and control to their light fixtures to accommodate their needs and preferences.	F 558		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still	F 578		4/23/21

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legally responsible for ensuring that the requirements of this section are met.
(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.
(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.
Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews the facility failed to maintain accurate advance directives throughout the medical records for 2 of 18 residents reviewed for advance directives (Resident #129 and Resident #51).

The finding included:

1. Resident #129 was admitted to the facility on 03/12/21 with diagnoses that included: cancer of the throat, trouble swallowing, respiratory disorder, and others.

Review of Resident #129's discharge summary dated 03/12/21 from the local hospital read in part, "palliative medicine was consulted on 02/06 and patient wished for code status to be changed to" Do Not Resuscitate (DNR).

Review of an admission assessment dated 03/12/21 indicated that Resident #129 was alert and oriented to person, place, and time. The

Preparation submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set fourth on the survey report. Our plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.

Resident #129 and Resident #51 advanced directives were reviewed and corrected.

All residents have the potential to be affected. All residents were assessed and no additional issues were identified.

The Director of Nursing / Designee provided re-education to all licensed nurses on advanced directives policy and

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F 578	Continued From page 8 assessment also indicated that Resident #129's long- and short-term memory were intact. Review of Resident #129's physician order summary dated 03/12/21 revealed no order for code status (either full code or DNR). Review of a Minimum Data Set (MDS) dated 03/19/21 that remained in progress indicated that Resident #129 was cognitively intact for daily decision making. Review of Resident #129's medical record on 03/23/21 revealed a document titled "Advance Directives/Medical Treatment Decisions Acknowledgement of Receipt" signed by Resident #129 with no date noted revealed that DNR had been checked. Further down on the form someone had wrote FULL CODE. No staff signature was noted on the form. An interview was conducted with Resident #129 on 03/24/21 at 10:07 AM. Resident #129 stated that someone either at the facility or in the hospital discussed code status with her. She stated that whoever discussed it with her did a wonderful job educating her on the facts. Resident #129 stated that when she admitted to the facility, she chose to be a DNR and she relayed that to the facility staff. An interview was conducted with the Unit Manager (UM) on 03/24/21 at 2:24 PM. The UM stated that code status was a part of the admission process and the admission nurse should have the conversation with the resident to determine their code status. Once the code status was made the order should be entered into the electronic medical record and the appropriate	F 578	requirement to obtain an order for the Code Status and/or Advance Directive. This will be documented in the clinical record. Residents/Responsible Parties will be interviewed upon admission for code status. An order will be obtained by the MD/GPN. The admitting nurse will enter the code status in the electronic medical record and the hard chart. Upon hire all new nurses and agency nurses will be trained for code status/advance directives. The Director of Nursing / Designee will conduct weekly code status audits for of all new admissions/ readmissions weekly for (12) twelve weeks to ensure code status matches throughout the electronic medical record and the hard chart. The Director of Nursing/Infection Control Nurse will report results of the audits in the facility's monthly QAPI meeting.	

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paperwork completed. The UM reviewed Resident #129's electronic medical record and physical chart and could not discern Resident #129's code status.

An interview was conducted with the Assistant Director of Nursing (ADON) on 03/24/21 3:50 PM. The ADON stated that she had assisted with Resident #129's admission. The ADON stated during the admission process Resident #129 along with her family indicated that Resident #129 wanted to be a DNR. The ADON stated had checked the DNR box on the Advance Directives/Medical Treatment Decisions Acknowledgement of Receipt form and had Resident #129 sign the form. Resident #129's family indicated they had the DNR at home and would bring to the facility. The ADON stated that she did not know who or why someone wrote FULL CODE on the bottom of the form but that was an error.

An interview with the Director of Nursing (DON) was conducted on 03/25/21 at 3:55 PM. The DON stated that code status should be obtained during the admission process and the order immediately entered into the electronic medical record so that both the electronic record and hard copy chart matched. She added that during the admission process Resident #129's family stated that they would bring the DNR to the facility.

2. Resident #51 was admitted to the facility on 01/21/21 with diagnoses included hemiplegia, diabetes mellitus, and neurogenic bladder. She was discharged to hospital on 02/01/21 and later readmitted to the facility on 02/03/21.

Review of admission Minimum Data Set dated

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01/28/21 assessed Resident #51 with intact cognition, adequate hearing, and clear speech.

Review of the electronic and hard copy clinical records for Resident #51 revealed there was no documentation related to medical code status or an advance directive.

Review of physician's order for Resident #51 revealed no orders related to medical code status or advance directives were in place.

During an interview with Resident #51 on 03/23/21 at 10:19 AM she stated none of the staff had ever asked her questions related to medical code status since her admission on 01/21/21. She indicated she wanted to be in full code.

During a phone interview with Nurse #6 on 03/25/21 at 12:24 PM he stated he was the nurse who had readmitted Resident #51 to the facility from the hospital on 02/03/21. He could not recall whether he had input the medical code status for Resident #51 during her readmission.

During an interview with the Assistant Director of Nursing (ADON) on 02/25/21 at 2:13 PM she stated it was her expectation for all the medical code status or advance directives to be documented and placed at a prominent location of clinical records during admission or readmission to ensure accessibility during emergency.

During an interview with the Administrator on 03/25/21 at 2:35 PM he stated it was his expectation for all the medical code status or advance directives to be documented in clinical records during admission or readmission

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F 578	Continued From page 11 process. During a phone interview with the Director of Nursing on 03/25/21 at 4:39 PM she expected the admitting nurse to confirm medical coding status or advance directives during admission or readmission and document it in the prominent part of clinical records in a timely manner.	F 578		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable	F 583		4/23/21

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F 583	Continued From page 12 federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and record review, the facility failed to provide privacy while providing incontinence care for 1 of 1 resident reviewed for privacy (Resident #44). Findings included: Resident #44 was admitted to the facility on 04/04/20 with diagnoses that included a cerebral infarction, diabetes, and chronic obstructive pulmonary disease (COPD). Resident #44's quarterly Minimum Data Set (MDS) dated 2/10/21 revealed she had moderate cognitive impairment and required extensive assistance from staff for bed mobility, dressing, hygiene, toileting, and dependent for bathing activities. The MDS indicted Resident #44 was frequently incontinent of bladder and always incontinent of her bowels. An observation on 3/24/21 at 3:00 PM revealed Nurse Aide (NA #1) entered the room to provide incontinence care for Resident #44. As NA #1 provided incontinence care to Resident #44 he did not draw the privacy curtain, nor did he close the resident's door to room prior to providing incontinence care An interview with Resident #44 on 03/24/21 at	F 583	Preparation submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set fourth on the survey report. Our plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. The Director of Nursing/ Designee provided education to NA#1 to pull the cubicle curtain around the resident's bed, close the resident's blinds and door before providing incontinence care. All residents have the potential to be affected. All residents were assessed and no additional issues were identified. The Director of Nursing / Designee conducted an in-service to all nursing staff which includes new hires on dignity including to pull the cubicle curtain around the resident's bed and close the resident's blinds and door before providing incontinence care. All nursing staff will be provided education on dignity and privacy for residents dignity	

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F 583	Continued From page 13 3:20 PM revealed Resident #44 stated she had been a nurse for several years and nudity did not bother nor offend her. She explained staff have never closed the door and rarely pull the curtain around her bed during care. An interview with NA #1 on 03/24/21 at 3:30 PM revealed he was assigned to provide care for Resident #44 on 3/24/21 and he had been educated to pull the privacy curtain and shut the door when providing incontinence care but did not think to do either when he provided care for Resident #44. A telephone interview with the Director of Nursing (DON) on 03/25/21 at 4:39 PM revealed she expected all staff to provide and ensure Resident #44 and all other residents in the facility were provided privacy 100 percent of the time during care activities An interview with the Administrator on 3/25/21 at 5:00 PM revealed he expected all residents to be provided privacy during incontinence care.	F 583	training will be added to new employee orientation. All resident rooms will have cubicle curtains and working blinds. Staff will report to the Maintenance Director if blinds are not working or if cubicle curtains are not in place. The Director of Nursing / Designee will conduct dignity audits weekly for (3) three residents a week times (4) weeks, (2) residents a week times (4) weeks and (1) one resident a week times (4) weeks. The Director of Nursing / Designee will report results of the audits in the facility's monthly QAPI meetings.	
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 observations, record review, and facility staff interviews the facility failed to accurately code the Minimum Data Set Assessment for the presence of a pressure ulcer (Resident #56) and a significant weight loss (Resident #26) for 2 of 2 residents reviewed for	F 641	Preparation submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set fourth on the survey report. Our plan of correction is prepared and executed as	4/26/21

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F 641	Continued From page 14 falls. 1. Resident #56 was admitted to the facility on 12/17/20 with diagnoses that included type II diabetes mellitus and acquired absence of left leg below the knee. A review conducted on 03/24/21 of Resident #56's most recent quarterly Minimum Data Set (MDS) Assessment dated 02/20/21 revealed Resident #56 was cognitively intact for daily decision making with no instances of rejection of care. Resident #56 was coded as requiring extensive assistance with bed mobility and transfer. She was coded as not having a pressure ulcer or injury. Review of Resident #56's Weekly Pressure Ulcer Record dated 03/08/21 revealed documentation of an existing pressure ulcer to her right lower leg. The onset date of the pressure ulcer was 12/19/20. Additional review of the record revealed the wound was noted as present on admission. During an interview with MDS Nurse #2 on 03/25/21 at 2:46 PM, she verified she was responsible for completing resident #56's 2/20/21 MDS assessment. She confirmed Resident #56 had a pressure ulcer present at the time the assessment was completed. After reviewing the 2/20/21 MDS assessment, she confirmed the assessment had been coded incorrectly. MDS Nurse #2 reported she must have "miss-clicked" the box and would correct the error immediately. An interview with the Director on Nursing on 03/25/21 at 4:04 PM revealed she expected Minimum Data Set Assessments to be completed	F 641	a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. On 4/13/21, the Director of Nursing (DON) validated that the modification of resident #56 MDS with ARD 2/22/21 and resident #26 MDS with ARD 12/30/21 was completed to correct coding of pressure ulcers present for resident #56 and weight loss for resident #26, was made and reflected accurate coding and was submitted to CMS. The MDS's for Resident #56 and #26 have been modified to reflect accurate coding of each section. An audit of all current residents having an MDS completed in the last 14 days will be completed to verify accurate coding of weight loss in Section "K" and the presence of pressure ulcers in Section "M". The audit will be completed by RCMD (Resident Care Management Director). Corrections will be made as identified per the RAJ manual guidelines. The audit was completed by the registered dietician and/or the RCMD by 4/23/21. All modifications were completed on 4/26/21. The MDS Coordinator and the Dietary Manager were in serviced by the Resident Care Management Director (RCMD) on the accurate coding of sections "K" and "M" on the MDS assessment per the RAI manual.	

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F 641	Continued From page 15 accurately. She continued, stating if Resident #56 had an identified pressure ulcer at the time of the assessment, it should have been reflected and coded correctly on the assessment at the time it was completed. 2. Resident #26 was admitted to the facility on 12/01/17 and re-admitted from the hospital on 12/20/20 with diagnoses that included Atrial Fibrillation (AFIB), Anemia secondary to Gastrointestinal (GI) bleeding, and Alzheimer's dementia. A Dietary note written by the Registered Dietician dated 12/20/20 indicated Resident #26 had a weight loss of 9.49% in 3 months and a 12.8% loss in 6 months with recommendations to add a fortified nutritional shake for an appetite stimulant. Resident #26's 5 day/quarterly Minimum Data Set (MDS) dated 12/30/20 indicated Resident 26's weight was 143 pounds (lbs.) with no significant weight loss noted. Resident #26's quarterly MDS dated 1/21/21 indicated Resident #26's weight was 149 lbs. with no significant weight loss noted. An interview with the Dietary Manager on 3/23/21 at 9:00 AM revealed she had completed the weight section of the MDS dated 12/30/20 and 1/21/21 and did not indicated Resident #26 had an unplanned weight loss. She indicated she was unclear about completing the section since the resident had recently been hospitalized. An interview with MDS Nurse #1 and MDS Nurse	F 641	The RCMD / Designee will document random MDS audits for coding accuracy of weight loss in Section K and presence of pressure ulcers in Section "M" on the MDS assessment per the RAI manual. The RCMD / Designee will document random MDS audits for coding accuracy of weight loss in Section K and presence ulcers in Section M of (3) three completed MDS's per week times (4)four weeks, then (2) two a week times (4) weeks, then (1) one resident a week for (4) weeks to ensure compliance is achieved and maintained. The Director of Nursing / Designee will review results of the random audits and those findings will be reported at the monthly QAPI meeting monthly until substantial compliance has been achieved. The Director of Nursing will be responsible for the implementation of the acceptable plan of correction.	

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F 641	Continued From page 16 #2 on 3/23/21 at 3:55 PM revealed they were the nurses who oversaw the completion of Resident #26's MDS assessments dated 12/30/20 and 1/21/21. They stated it was important for all portions of the assessment to be accurate. An interview with the Assistant Director of Nursing on 3/24/21 at 4:50 PM which revealed she was unaware there were inaccuracies on the MDS's dated 12/30/20 and 1/21/21, but she expected any staff member who completed portions of the MDS to assure the accuracy of the information when completing the assessment.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will	F 656		4/23/21

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F 656	Continued From page 17 provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to develop a care plan for an indwelling urinary catheter (Resident #59) and failed to implement the care plans for catheter stabilizing devices (Resident #3) for 2 of 3 residents reviewed for indwelling urinary catheters. The findings included: 1. Resident #59 was admitted to the facility on 02/24/21 with diagnoses that included neurogenic bladder and had an indwelling urinary catheter. The admission Minimum Data Set (MDS) assessment dated 03/03/21 revealed Resident #59 had moderately impaired cognition. The MDS also indicated the Resident had an indwelling urinary catheter and had diagnoses that included	F 656	Preparation submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set fourth on the survey report. Our plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. Resident #59 and #3 obtained a physician's order and care plan for an indwelling urinary catheter and applied a securement device for the resident's indwelling urinary catheter. All residents who currently use catheters were reviewed by the Director of Nursing	

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F 656	Continued From page 18 benign prostatic hyperplasia (enlarged prostate gland that could cause urinary difficulties) and neurogenic bladder. Resident #59's care plans were reviewed on 03/22/21. No care plan was observed that addressed the indwelling urinary catheter use or care. On 03/24/21 at 11:29 during an interview with the Unit Manager (UM) she explained that the care plan for Resident #59's urinary catheter should have been developed on admission by the admitting nurse. She continued to explain that in the event the admitting nurse did not initiate the care plan the MDS Nurse should have initiated it when she completed the MDS assessment. An interview was conducted with MDS Nurse #1 and MDS Nurse #2 on 03/25/21 at 3:43 PM. MDS Nurse #1 explained Resident #59 did not have an order for a urinary catheter and that was why she missed it when she reviewed his medical record to complete the admission MDS which would have triggered the care plan to be developed. MDS Nurse #2 stated it was discovered on 03/23/21 that Resident #59 did not have a care plan to address the urinary catheter, so she completed one on 03/23/21. During an interview with the Director of Nursing on 03/25/21 at 3:55 PM she explained that the care plan for Resident #59's urinary catheter should have been initiated on admission and in the event the care plan was not initiated then the MDS nurses should have caught it when they completed his admission assessment and developed a care plan.	F 656	to ensure a securement device was applied for all residents who use a foley catheter as indicated by the residents plan of care. All residents have the potential to be affected. All residents were assessed and no additional issues were identified. The Director of Nursing / Designee re-educated all nursing staff which includes new hires on bowel and bladder management clinical system. This includes to notify the license nurse for placement of catheter securing device and implement the care plans for the indwelling urinary catheter. The nursing staff will be educated on catheter care and responsibility for all nursing staff to ensure anchor is in place. All nurses and resident care specialists (CNA) will be responsible for replacing the anchor. Each resident will have an order placed on the TAR to verify securement in place. All nursing staff has been educated on how to replace a securement. The agency nursing staff will be educated upon hire by the DON/ADON/Designee. The Bowel and Bladder Management System will be added to new employee orientation. A urinary catheter audit will be conducted for catheters, orders, approved diagnosis of catheter, catheter securing device and care plan (3) three a week times (4)four weeks, (2) two a week times (4) four weeks and (1) once a week times (4) four	

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F 656	Continued From page 19 2. Resident #3 was admitted to the facility on 12/18/20 with diagnoses that included neurogenic bladder and had an indwelling urinary catheter. A review of Resident #3's Treatment Administration Record dated 01/29/21 indicated the use of a urinary catheter stabilizing device to reduce the excessive tension on the tubing and to facilitate urine flow. The care plan for Resident #3's urinary catheter dated 02/01/21 revealed the Resident had a urinary catheter and would remain free from catheter related trauma by anchoring the catheter to prevent excess tension. A significant change Minimum Data Set (MDS) assessment dated 03/23/21 revealed Resident #3 was cognitively intact and had an indwelling urinary catheter due to a diagnosis of neurogenic bladder. On 03/23/21 at 3:26 PM an interview and observation of Resident #3 revealed, the Resident was lying in bed with an indwelling urinary catheter to bedside drainage and clear yellow urine in the catheter tubing and drainage bag. Resident had no stabilizing device on his thigh to secure the catheter tubing. Resident #3 explained it (the stabilizing device) came off a couple of nights ago and they have not put it back on. On 03/24/21 at 9:17 AM during an interview with Resident #3 he stated his stabilizing device was on because they came and put it on last night (03/23/21). On 03/24/21 at 10:11 AM an interview with the	F 656	weeks to ensure continued compliance. The Director of Nursing / Designee will report results of the audits in the facility's monthly QAPI meetings.	

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F 656	Continued From page 20 Wound Nurse (WN) revealed she was responsible for the routine audits of the indwelling urinary catheters that included the stabilizing devices were in place. The WN stated that Resident #3's stabilizing device was in place yesterday (03/23/21) morning because she checked it and the stabilizing device was in place. The WN explained if the residents' stabilizing devices come off during the time she was off duty, the staff waited until she came into the facility on her next scheduled day to work for her to replace the residents' stabilizing devices. On 03/25/21 12:29 PM during an interview with Director of Nursing #2 she explained that she performed a urinary catheter audit on Tuesday (03/23/21) evening and Resident #3 did not have a stabilizing device in place so she had the staff put one on him. On 03/25/21 at 3:55 PM a telephone interview was conducted with the Director of Nursing (DON). The DON explained that the residents with indwelling urinary catheters were supposed to have stabilizing devices in place to prevent trauma. She continued to explain that the WN was responsible for checking the residents with urinary catheters every day when she does the treatments to make sure they have a stabilizing device in place. The DON stated the responsibility fell to the nurses when the WN was not in the facility. The DON explained that the nurses were thoroughly educated about the urinary catheters and she expected the nurses to follow the facility policy regarding the urinary catheters, even the agency nurses.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677		4/23/21

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F 677	Continued From page 21 §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and record review, the facility failed to provide routine incontinence care to a resident with a Stage IV pressure ulcers to the sacrum and to provide nail care to a dependent resident who was observed to have long, sharp, and jagged fingernails with dark color debris underneath the nails for 1 of 5 resident reviewed for activities of daily living (ADL) (Resident #44). Findings included: 1. Resident #44 was admitted to the facility on 04/04/20 with diagnoses that included a cerebral infarction, diabetes, adult failure to thrive, major depressive disorder, and chronic obstructive pulmonary disease (COPD). Resident #44's Quarterly Minimum Data Set (MDS) dated 2/10/21 revealed she was cognitively impaired at the moderate level and required extensive assistance from staff for bed mobility, dressing, hygiene, toileting, and dependent for bathing activities. The MDS indicted Resident #44 was frequently incontinent of bladder and always incontinent of her bowels and has a Stage IV pressure ulcer. A facility shower sheet for the 300-hall revealed Resident #44 was to receive showers/bathing twice weekly on Monday and Thursdays.	F 677	Preparation submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set fourth on the survey report. Our plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. Resident #44 nails have been trimmed/filed and cut down on 3/26/21. . On 4/21/21 the Director of Nursing / Designee provided education to NA#1 to pull the cubicle curtain around the resident's bed, close the resident's blinds and door before providing incontinence care and remove scrunched linen under the resident. Rounds are encouraged, even when the call light is not on. On 4/21/21 the Director of Nursing / Designee provided education to NA#2 on ADL's including nail care. All residents have the potential to be affected. On 4/23/21 all residents were assessed on nail care, incontinent care and no additional issues were identified.	

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F 677	Continued From page 22 Resident #44's bathing grid for March 18, 2021 through March 25, 2021 revealed she received bathing assistance on 3/18/20, 3/20/21 and 3/21/21. An observation and interview with Resident #44 on 3/22/21 at 11:18 AM revealed she was lying in bed with fingernails 3 to 4 millimeter (mm) in length and the left middle finger was chipped with sharp edges. Resident #44 stated she could not recall the last time staff had trimmed/filed her fingernails but wished for them to be cut all the way down. An observation and interview with Resident #44 on 3/23/21 at 10:01 AM revelaed Resident #44's fingernails remained untrimmed with sharp edges. Resident #44 was observed to have multiple circular open areas on her face with what appeared to be bloody scabs attached. One area was noted to have fresh blood pooling at the site. Resident #44 indicated she was aware her face had open areas and stated the areas itched and when she is upset, she scratches her face frequently. Resident #44 explained she feels like staff do not check on her as frequently as they do her roommate and she often sat wet in urine and she doesn't receive nail care as often as other residents. An observation and interview with Resident #44 on 3/24/21 at 1:43 PM revealed Resident #44 lying in bed reading a book. Resident #44's call light was on. Resident #44's lower body was exposed, and she was sitting on two green disposable chuck pads and indicated she was soiled in urine and had been waiting for staff to assist her with getting cleaned up. Resident #44's nails remained uncut or cleaned. She indicated	F 677	On 4/15/21 the Director of Nursing / Designee conducted an in-service in all nursing staff which includes new hires on ADL's including nail care, showers, foot care, facial hair, clothing, grooming and incontinent care. Training and re-education included to provide nail care on scheduled showers and PRN. The cubicle curtain must be pulled around the resident's bed, close the resident's blinds and door before providing incontinence care. The air mattress covers are to be washed and cleaned on shower days and PRN. All extra linen will be removed from the bed and only use chuck pads on the air mattress to prevent scrunched linen under the resident. Incontinent care when making rounds are encouraged, even when the call light is not on. The Director of Nursing / Designee will conduct ADL audits for (3) three residents a week times (4) weeks, (2) two residents a week times (4) weeks and (1) one resident a week times (4) four weeks. ADL training will be added to new employee education. The Director of Nursing / Designee will report results of the audits in the facility's monthly QAPI meetings.	

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she had told the NA who had bathed her last that they could trim and file her nails but they did not return to do so after bathing her and she was unable to identify which NA she had given permission.

An observation and interview with Resident #44 on 3/24/21 at 3:00 PM revealed Resident #44 lying in her bed with the sheet positioned at the foot of her bed. She was sitting on disposable chuck pads and had a white cloth pillowcase scrunched up behind her backside. When NA #1 entered the room to provide incontinence care, both the green chuck disposable pads and the pillowcase were saturated with yellow urine that had made its way up Resident #44's back and had caused the air mattress to become soiled due to the cover not being attached properly.

An interview with NA #1 on 03/24/21 at 3:30 PM revealed he was the nursing assistant assigned to provide care for Resident #44 on 3/24/21 and explained Resident #44 was alert and would typically call for assistance when she had soiled herself but he didn't routinely go in to offer incontinence care unless Resident #44 requested.

A telephone interview with NA #2 on 3/24/21 at 3:32 PM revealed he had been assigned to provide for her care over the weekend. NA #2 indicated he had entered Resident #44's room to change her on a routine incontinence round but found her to be soiled with urine and feces and elaborated to say she had her hands in the feces then touched the bed and rails which resulted in him providing a bed bath to Resident #44 and cleaning her entire bed. NA #2 explained Resident #44 had mentioned to him about her

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F 677	Continued From page 24 fingernails needing to be trimmed, but he got busy and did not make it back to her room to complete nail care during his shift nor report it to the oncoming shift. An observation and interview with Resident #44 on 3/25/21 at 10:2 AM revealed Resident #44 lying in bed with green disposable chuck pads underneath her. The call light was on when the surveyor entered the room and Resident #44 indicated she had been waiting to be dried. Nurse #4 entered the room to answer the call light and said she would get a staff member to assist with incontinence care and exited the room. A telephone interview with the Director of Nursing (DON) on 03/25/21 at 4:39 PM revealed she expects all residents to be checked every two hours and as needed for incontinence care needs to prevent skin breakdown or further skin breakdown to residents known to have skin care concerns. She also expects nail care to be provided twice weekly with bathing and as needed to prevent potential self-inflicted injuries from long or jagged fingernails. An interview with the Administrator on 3/25/21 at 5:00 PM revealed he expected residents to receive nail care with showers or as needed. He indicated nails should not be left sharp and jagged for potential injury to the resident.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive	F 684		4/23/21

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F 684	Continued From page 25 assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations and facility staff and resident interviews, the facility failed to ensure the wellbeing of a resident by not notifying the nurse of complaints of pain due to overgrown toenails so that a nurse could assess the resident for 1 of 1 resident reviewed for wellbeing (Resident #63). Findings Included: Resident #63 was admitted to the facility on 09/08/20 with diagnoses that included cerebral hemiplegia and hemiparesis following a stroke affecting the left non-dominant side, muscle weakness, chronic pain, and contracture to left hand, and type II diabetes mellitus. A review of Resident #63's most recent quarterly Minimum Data Set Assessment dated 02/24/21 revealed Resident #63 to be cognitively intact for daily decision making with no psychosis, behaviors, or instances of rejection of care. Resident #63 was coded as requiring extensive assistance with bed mobility, transfer, dressing, toilet use and personal hygiene. Resident #63 was totally dependent on others for bathing. During an initial observation and interview with Resident #63 on 03/22/21 at 10:37AM, he reported he was feeling some discomfort and pain with his left foot. He reported he felt this was due to his toenails being too long. He reported his toenails had grown over the tips of his toes	F 684	Preparation submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set fourth on the survey report. Our plan of correction s prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. Resident #63 was assessed and toe nails filed. The podiatrist on 4/16/21 saw the resident at the facility and cut resident#63 toe nails. The Director of Nursing re-education to the Restorative Aide #1 to report to a licensed nurse for any resident that is in pain and/or change of condition using the stop and watch tool. All residents have the potential to be affected. All residents were assessed and no additional issues were identified. The Director of Nursing / Designee conducted an in-service to all nursing staff which includes new hires to notify the license nurse for pain and / or change of condition using the Stop and Watch tool forms.	

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F 684	Continued From page 26 and were beginning to curl back under the pads of his toes. He stated the podiatrist had visited him last week but for some reason, did not clip all the nails on his feet. He reported he did not know why several toenails were clipped and others were not. An observation completed 03/24/21 at 9:58 AM revealed Resident #63 in the hallway working with Restorative Aide #1 with ambulation. During that time, Resident #63 was heard telling Restorative Aide #1 that his foot was hurting from his nails being too long and requested they be trimmed. Restorative Aide #1 was observed dismissing Resident #63 and continued with the therapy. During an interview with Restorative Aide #1 on 03/25/21 at 11:01 AM she reported that she remembered Resident #63 informing her about pain in his left foot and stated "he says that all the time". She reported she could not remember if she notified the hall nurse of Resident #63's pain in his left foot. She verified facility policy was to report pain or discomfort to a nurse if a resident notified them of pain. During an interview with Hall Nurse #3 on 03/25/21 at 12:22 PM, she reported Restorative Aide #1 never notified her of Resident #63's complaint of pain in his left foot. She reported she "hoped" that a nurse aide or restorative aide would notify her if a resident complained of pain, despite if it was a frequent complaint. She stated is she is unaware of a resident's complaint of pain or discomfort, then she could not treat it. During an interview with the Director of Nursing on 03/25/21 at 4:04PM she reported she expected her staff to immediately notify the nurse	F 684	Notification of change in condition using stop and watch tool will be added to new employee orientation for all nurses and resident care specialists (certified nursing assistants). The Director of Nursing / Designee will conduct audits of stop and watch tool for (3) three times a week times (4) weeks, (2) two times a week times (4) four weeks and (1) once a week times (4) weeks. The Director Nursing / Designee will report results of the audits in the facility's monthly QAPI meetings.	

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F 684	Continued From page 27 if there was a resident complaining of pain or discomfort. In Resident #63's situation, she would have expected the restorative aide to tell his hall nurse that he was experiencing discomfort and pain related to his toenails immediately upon hearing his complaint. She reported it did not matter if the resident has routine complaints, it should have been addressed at that time.	F 684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.	F 690		4/23/21

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F 690	Continued From page 28 §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 observations, record reviews, staff and resident interviews, the facility failed to obtain a physician's order for an indwelling urinary catheter (Resident #59) and failed to apply a stabilizing device for residents' indwelling urinary catheters (Resident #3, #59 and #66) for 3 of 3 residents reviewed for urinary catheters. The findings included: 1. Resident #59 was admitted to the facility on 02/24/21 with diagnoses that included neurogenic bladder and had an indwelling urinary catheter. A review of Resident #59's medical record and the admitting orders revealed no order for an indwelling urinary catheter. A review of Resident #59's Treatment Administration Records for February and March 2021 revealed no order for an indwelling urinary catheter or a stabilizing device. A review of a Nurse Practitioner (NP) progress note dated 02/26/21 indicated Resident #59's catheter was draining clear yellow urine and listed diagnoses of benign prostatic hyperplasia (enlarged prostate gland that can cause urinary difficulty) with obstruction and urinary retention.	F 690	Preparation submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set fourth on the survey report. Our plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. On 3/24/21 resident #59, #3 and #66 obtained a physician's order for an indwelling urinary catheter and applied a securement device for the resident's indwelling urinary catheter on 3/24/21. All residents who currently use catheters were reviewed by the Director of Nursing to ensure a securement device was applied for all residents who use a foley catheter as indicated by the residents plan of care. The Director of Nursing / Designee re-educated licensed nursing staff on bowel and bladder management clinical system including, to obtain a physician's order and placement of a catheter	

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F 690	Continued From page 29 The admission Minimum Data Set (MDS) assessment dated 03/03/21 revealed Resident #59 had moderately intact cognition. The MDS also indicated the Resident had an indwelling urinary catheter and had diagnoses that included benign prostatic hyperplasia and neurogenic bladder. A review of Resident #59's care plans revealed there was no care plan for the care of his indwelling urinary catheter. On 03/23/21 at 2:16 PM an observation was made of Resident #59 sitting in a wheelchair in his room. The Resident's urinary catheter bag was hooked to the wheelchair and had yellow urine in the catheter tubing. There was no stabilizing device secured to the Resident's thigh to prevent pulling on On 03/24/21 at 9:02 AM an interview and observation was made of Resident #59 lying in bed. When the Resident was asked if he had a stabilizing device in place, he shook his head no then pulled the cover back to allow an observation of no stabilizing device on either thigh. On 03/24/21 at 9:49 AM an interview was conducted with Nurse Aide (NA) #3 who explained that the residents with urinary catheters had to have a catheter stabilizing device in place to prevent from pulling the catheter and causing damage. The NA continued to explain that the Wound Nurse (WN) applied the stabilizing devices and if the devices come off during care then they notified the WN. Observation of Resident #59's urinary catheter during the	F 690	securing device. Each resident will have an order placed on the TAR to verify securement in place. All nursing staff has been educated on how to replace a securement. The agency nursing staff will be educated upon hire by the DON/ADON/Designee. The Bowel and Bladder Management clinical system will be added to new employee orientation for all licensed nurses. The Director of Nursing / Designee will review new admissions and readmissions with catheters to ensure that there is a physician order and the foley catheter are anchored and a care plan is in place. The DON / Designee will complete urinary catheter audits for catheters/ orders/approved diagnosis of catheter and catheter securing device for (3) three weeks times (4) weeks, (2) two weeks times (4) weeks, (1) once a week times (4) weeks to ensure continued compliance. The Director of Nursing / Designee Nurse will report results of the audits in the facility's monthly QAPI meetings. The QAPI committee will evaluate the effectiveness of the above plan and will add additional interventions based on identified trends/outcomes to ensure continued compliance.	

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interview revealed no stabilizing device in place to the Resident's thigh. NA #3 stated she would notify the WN.

During an interview with the Wound Nurse on 03/24/21 at 10:01 AM she confirmed NA #3 informed her that Resident #59's stabilizing device was not in place. The WN explained that she was responsible for the routine audits of the urinary catheters which included making sure there were orders for the catheters and the care of the catheters were in place on the resident's Treatment Administration Records (TAR) that included the stabilizing device. She continued to explain that she knew Resident #59 had a catheter because she helped admit him on 02/24/21. The WN pulled up the Resident's TAR and stated the checking of the stabilizing device was not on the TAR for the nurses to check if she was not on duty. When asked how the nurses would know to check Resident #59's stabilizing device if it was not on his TAR the WN stated the nurses would not know to check for it. The WN stated she knew Resident #59 had a stabilizing device on yesterday (03/23/21) morning because she checked it herself. She also stated that she worked until 4:30 PM during the week and was off on the weekends and if the residents' stabilizing devices come off during the time she was not on duty then the staff waited until she came in to the facility on her next day to work for her to replace the residents' stabilizing devices.

An interview was conducted with the District Director of Clinical Services (DDCS) on 03/25/21 at 12:49 PM who explained that Resident #59 should have had an order for the urinary catheter and the supporting diagnosis for the catheter on admission and he should have been evaluated on

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admission as to continue the catheter or discontinue it. She continued to explain that nothing was set up on the TAR as far as to monitor, change or anchorage of the catheter and the nursing leadership team should have captured that when they done the 24 hour chart check the next morning.

2. Resident #3 was admitted to the facility on 12/18/20 with diagnoses that included neurogenic bladder and had an indwelling urinary catheter.

A review of Resident #3's Treatment Administration Record dated 01/29/21 indicated the use of a urinary catheter stabilizing device to reduce the excessive tension on the tubing and to facilitate urine flow.

The care plan for Resident #3's urinary catheter dated 02/01/21 revealed the Resident had a urinary catheter and would remain free from catheter related trauma by anchoring the catheter to prevent excess tension.

A significant change Minimum Data Set (MDS) assessment dated 03/23/21 revealed Resident #3 was cognitively intact and had an indwelling urinary catheter due to a diagnosis of neurogenic bladder.

On 03/23/21 at 3:26 PM an interview and observation of Resident #3 revealed, the Resident was lying in bed with an indwelling urinary catheter to bedside drainage and clear yellow urine in the catheter tubing and drainage bag. Resident had no stabilizing device on his thigh to secure the catheter tubing. Resident #3 explained it (the stabilizing device) came off a couple of nights ago and they have not put it back

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on.

On 03/24/21 at 9:17 AM during an interview with Resident #3 he stated his stabilizing device was on because they came and put it on last night (03/23/21).

On 03/24/21 at 10:11 AM an interview with the Wound Nurse (WN) revealed she was responsible for the routine audits of the indwelling urinary catheters that included the stabilizing devices were in place. The WN stated that Resident #3's stabilizing device was in place yesterday (03/23/21) morning because she checked it and the stabilizing device was in place. The WN continued to state that she worked until 4:30 PM during the week and was off on the weekends and if the residents' stabilizing devices come off during the time she was off duty, the staff waited until she came into the facility on her next scheduled day to work for her to replace the residents' stabilizing devices.

On 03/25/21 12:29 PM during an interview with the Director of Nursing #2 she explained that she performed a urinary catheter audit on Tuesday (03/23/21) evening and Resident #3 did not have a stabilizing device in place so she had the staff put one on him.

On 03/25/21 at 3:55 PM a telephone interview was conducted with the Director of Nursing (DON). The DON explained that the residents with indwelling urinary catheters were supposed to have stabilizing devices in place to prevent trauma. She continued to explain that the WN was responsible for checking the residents with urinary catheters every day when she does the treatments to make sure they have a stabilizing

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device in place. The DON stated the responsibility fell to the nurses when the WN was not in the facility. The DON explained that the facility audited the urinary catheters for 6 months and all the nurses were thoroughly educated about the urinary catheters and she expected the nurses to follow the facility policy regarding the urinary catheters, even the agency nurses.

#3. Resident #66 was admitted to the facility on 12/16/20 with diagnoses that included stroke, unspecified dementia without behavioral disturbance, hemiplegia and hemiparesis following a stroke, and neuromuscular dysfunction of the bladder.

Review of Resident #66's most recent quarterly Minimum Data Set Assessment revealed resident to be moderately impaired for daily decision making with no psychosis, behaviors, rejection of care, or instances of wandering. Resident #66 was coded as requiring extensive assistance with mobility, transfer, toilet use, and personal hygiene. He was coded as having an indwelling catheter in place due to a diagnosis of neurogenic bladder.

Review of Resident #66's electronic physician orders revealed an order for "Use catheter securing device to reduce excessive tension on the tubing and facilitate urine flow.

A review of Resident #66's care plan last reviewed on 02/10/21 revealed a care plan are for "[Resident #66] has a catheter due to neurogenic bladder. Interventions included: "Anchor catheter to prevent excess tension".

During an observation and interview with

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Resident #66 on 03/22/21 at 12:19 PM, he indicated that his catheter tubing was not anchored. Resident #66 denied pain or pulling at that time.

During a follow-up observation and interview with Resident #66 on 03/23/21 at 3:09PM he reported again that his catheter tubing was not anchored to his leg. He stated that tape does not stick to his leg and was unaware there were other options to anchor his catheter tubing to his leg. An observation of his catheter tubing at that time verified his statement of the catheter tubing not being anchored to his leg and was observed running up from the catheter bag, over the side of the bed and running underneath Resident #66's brief.

An observation of Resident #66's catheter tubing on 03/25/21 at 11:37 revealed it to continue to be unanchored.
During an interview with Nurse #6 on 03/25/21 at 2:24PM revealed he does not typically work on the hall where Resident #66 resided and was unfamiliar with Resident #66. He did report that catheter tubing should be anchored and checked daily. He did not know when the last time Resident #66's catheter tubing would have been checked or why the tubing had not been anchored. He stated he would immediately attend to the unanchored catheter tubing.

During an interview with the Director of Nursing on 03/25/21 at 4:04PM, she reported that wound care nurses were
responsible for ensuring the placement of catheter anchors and she expected the anchors to be checked and verified weekly or daily, depending o the wound treatments of the

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F 690	Continued From page 35 particular resident. She also expected hall nurses to check for securement of catheter tubing when wound nurses were not present in the building. She also reported if a resident in the facility had a catheter, then she expected it to be anchored.	F 690		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.	F 756		4/23/21

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F 756	Continued From page 36 §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, staff, and Consultant Pharmacist interviews the facility failed to follow up on the monthly pharmacist consultation report for 2 of 5 resident reviewed for unnecessary medications (Resident #34 and Resident #26). The finding included: 1. Resident #34 was admitted to the facility on 10/08/19 with diagnoses that included schizophrenia (mental health condition), anxiety, and others. Review of an Abnormal Involuntary Movement Scale (AIMS) assessment dated 11/15/19 revealed a score of 0. This was the most recent AIMS scored noted in Resident #34's medical record. Review of a Consultation Report dated 06/23/20 read in part, Resident #34 receives Paliperidone (antipsychotic). The last AIMS exam in her electronic chart is dated 11/15/19. Please perform a current AIMS and repeat every 6 months. The report was issued to Director of Nursing (DON) #1 from the Consultant Pharmacist (CP). Review of a Consultation Report dated 08/27/20 read in part, repeated recommendation from	F 756	Preparation submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set fourth on the survey report. Our plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. Resident #34 AIMS was completed by April 19, 2021. A Fish Bone Diagram Root Cause Analysis was conducted on 4/16/21. 1)The failure to complete an AIMS on resident #34 with a diagnosis of schizophrenia. Resident was discharged to the hospital and all of residents #34 assessments were deleted. (2) The User Define Assessment did not trigger when the resident was re-admitted back to the facility to be completed. The Root Cause Analysis was led by the Director of Nursing with input by the Assistant Director of Nursing Infection Preventionist and Nursing Home Administrator. The	

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F 756	Continued From page 37 06/23/20. Resident #34 receives Paliperidone. The last AIMS exam in her electronic chart is dated 11/15/19. Please perform a current AIMS and repeat every 6 months. The report was issued to DON #1 from the CP. Review of a Consultation Report dated 10/21/20 read in part, repeated recommendation from 06/23/20 and 08/27/20. Resident #34 receives Paliperidone. The last AIMS exam in her electronic chart is dated 11/15/19. Please perform a current AIMS and repeat every 6 months. The report was issued to DON #1 from the CP. Review of a Consultation Report dated 12/27/20 read in part, repeated recommendation from 06/23/20, 08/27/20, and 10/21/20. Resident #34 receives Paliperidone and Zyprexa (antipsychotic). The last AIMS exam in her electronic chart is dated 11/15/19. Please perform a current AIMS and repeat every 6 months. The report was issued to DON #1 from the CP. Review of a quarterly Minimum Data Set (MDS) dated 01/27/21 indicated that Resident #34 was moderately impaired for daily decision making and required extensive assistance with activities of daily living. The MDS further indicated that Resident #34 received an antipsychotic, antianxiety, and antidepressant during the assessment reference period. An interview was conducted with the Unit Manager (UM) on 03/24/21 at 2:24 PM. The UM stated that the monthly pharmacist consultation reports were emailed to DON #1 and she separated them into the ones for the medical provider and the ones that the nursing staff was able to take care. The UM further stated that	F 756	Results of the Root Cause Analysis were reviewed by the QAPI Committee on 4/16/21 were incorporated into the facility plan of correction. An admission check off list which has all of the UDS will be completed on admission. All Nurses completing admissions will be educated on this process. All new nurses/ agency nurses will be educated on the assessment upon admission and the readmission assessments process. The pharmacy recommendations will be given to the DON/ADON and copied to the nurse practitioner. Once the nurse practitioner completes them, they will be processed by the nursing staff. Once completed a copy will be given to the DON/ADON to verify completion before the end of the month. All pharmacy recommendations will be completed in a timely manner with audit tool to verify completion of all recommendations. All residents have the potential to be affected. All residents were assessed and no additional issues were identified. The DON / Designee will audit pharmacy recommendations, monthly for 50% recommendations monthly times monthly, 25% recommendations monthly times monthly and 10% recommendations monthly times monthly. The Director of Nursing / Designee will report results of the audits in the facility's	

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F 756	Continued From page 38 DON #1 would give the provider a copy of their reports and they would take care of them and DON #1 would take care of the others. Once they had been completed, she would sign off on them and file them in notebooks in her office. The UM went to DON #1's office and pulled the original consultation reports from 06/23/20, 08/27/20, 10/21/20, and 12/27/20 none of them had DON #1 signature indicating they had been taken care of. An interview was conducted with the Consultant Pharmacist (CP) on 03/24/21 at 3:55 PM. The CP stated that her monthly chart reviews were currently being conducted offsite due to the COVID-19 pandemic. The CP stated that the facility had a really good system with the medical providers and generally the recommendations got resolved very quickly. The CP stated she had not realized she had made so many requests for the AIMS score for Resident #34. For residents that are on antipsychotic she preferred to see an AIMS score every 6 months as part of the medication management. The CP reviewed Resident #34's AIMS score from 11/15/19 and stated she had no indication of any abnormal movements but ideally the consult recommendations should be followed up on by the next month's review. An interview was conducted with DON #1 on 03/25/21 at 3:55 PM. DON #1 stated that Resident #34 had been in and out of the hospital and she had not completed the recommendation in June 2020 because she had been out sick with COVID. She further explained that the AIMS assessment was set to automatically trigger for completion every quarter and she believed MDS Nurse #1 and MDS Nurse #2 were completing	F 756	monthly QAPI meetings.	

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them quarterly when they completed the other assessments. DON #1 explained that if the AIMS assessment was not set up to trigger for completion then she should have ensured that it was set up correctly in the electronic health record so that it would be completed timely.

An interview was conducted with MDS Nurse #1 on 03/25/21 at 5:05 PM. MDS Nurse #1 confirmed that when a resident admitted to the facility, they utilized batch orders for medications and if the resident was on a certain medication it would automatically trigger whatever assessment was required. She further explained that they do not complete the AIMS assessment that would be up to the hall nurses to complete. MDS Nurse #1 stated that it was possible that the medication batch order was not correctly entered and the AIMS assessment for Resident #34 was not triggering for completion.

An interview was conducted with MDS Nurse #2 on 03/25/21 at 5:09 PM. MDS Nurse #2 confirmed that the facility utilized batch orders on admission and if they were not entered correctly the corresponding assessment would not trigger for completion. She further explained that she did not complete AIMS assessment that would be up to the hall nurses.

2. Resident # 26 was re-admitted to the facility on 12/20/20 with diagnoses that included Atrial Fibrillation (AFIB), Anemia secondary to Gastrointestinal (GI) bleeding, and Alzheimer's dementia.

Resident #26's discharge summary dated 12/20/20 revealed the following orders: Levothyroxine Sodium 75 microgram (mcg) daily

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in the morning; Mirtazapine 7.5 milligram (mg) daily at bedtime; Olanzapine 5mg daily at bedtime; Omeprazole Delayed Release 20mg twice daily; Buspirone 5mg three times daily; and Sucralfate 1 GM (gram) four times per day; however, the discharge summary did not indicate a reason (diagnoses) for the medication orders.

A pharmacy recommendation dated 12/28/20 written by the facility's Pharmacy Consultant and addressed to the Director of Nursing (DON) indicated Resident #26's medical record list potentially inappropriate supporting diagnoses for indication for the following medications: "Buspirone for fracture and AFIB, Levothyroxine for osteoporosis, Mirtazapine for anemia, Olanzapine for AFIB, Omeprazole for AFIB, and Sucralfate for fracture/Alzheimer's/anxiety with recommendations to clarify an APPROPRIATE indication for the use of each medication and update the Medication Administration Record (MAR) accordingly."

A copy of the January Medication Review report was signed by the physician on 2/3/21 included the following orders: Levothyroxine Sodium 75 microgram (mcg) daily in the morning for osteoarthritis (OA); Mirtazapine 7.5 milligram (mg) daily at bedtime for unspecified anemia; Olanzapine 5mg daily at bedtime for unspecified AFIB; Omeprazole Delayed Release 20mg twice daily for unspecified AFIB; Buspirone 5mg three times daily for displaced intertrochanteric fracture of the right femur and unspecified AFIB; and Sucralfate 1 GM (gram) four times per day for displaced intertrochanteric fracture of the right femur, Alzheimer's dementia, and anxiety.

A pharmacy recommendation form dated 2/25/21

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written by the facility Pharmacy Consultant and addressed to the DON indicated: "REPEATED RECOMMENDATION from 12/28/20: Please respond promptly to assure facility compliance with federal regulations. It further indicated Resident #26's medical record list potentially inappropriate supporting diagnoses for the following medications: Buspirone for fracture and AFIB, Levothyroxine for osteoporosis, Mirtazapine for anemia, Olanzapine for AFIB, Omeprazole for AFIB, and Sucralfate for fracture/Alzheimer's/anxiety with recommendations to clarify an APPROPRIATE indication for the use of each medication and update the Medication Administration Record (MAR) accordingly."

A provider progress note written by the Nurse Practitioner (NP) dated 3/9/21 indicated the following reason for a visit: A medication and chart review per pharmacy recommendation. The note read in part pharmacy recommended Resident #26's diagnoses and medication orders be reviewed due to pharmacy believed her medical record list potentially inappropriate diagnoses for multiple medications and medication orders are clarified with the corrected corresponding diagnoses as followed: Levothyroxine Sodium 75 microgram (mcg) daily in the morning for hypothyroidism; Mirtazapine 7.5 milligram (mg) daily at bedtime for insomnia and mood; Olanzapine 5mg daily at bedtime for dementia with psychotic features; Omeprazole Delayed Release 20mg twice daily for reflux; Buspirone 5mg three times daily for anxiety; and Sucralfate 1 GM (gram) four times per day for reflux.

A review of Resident #26's March physician's

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orders and the March Medication Administration Record (MAR) conducted on 3/23/21 indicated the following orders: Levothyroxine Sodium 75 microgram (mcg) daily in the morning for osteoarthritis (OA); Mirtazapine 7.5 milligram (mg) daily at bedtime for unspecified anemia; Olanzapine 5mg daily at bedtime for unspecified AFIB; Omeprazole Delayed Release 20mg twice daily for unspecified AFIB; Buspirone 5mg three times daily for displaced intertrochanteric fracture of the right femur and unspecified AFIB; and Sucralfate 1 GM (gram) four times per day for displaced intertrochanteric fracture of the right femur, Alzheimer's dementia, and anxiety.

An interview with the Unit Manager on 3/23/21 at 3:00 PM revealed she was recently promoted to the Unit Manager on day shift. The Unit Manager reviewed the orders of Resident #26 on 3/23/21 and stated they were entered by an agency nurse who is no longer employed with the facility. The Unit Manager revealed the correct supporting diagnoses should have been included in the orders on admission or clarification orders should have been obtained on the day of admission and no later than the following day. The Unit Manager explained the usual procedure for obtaining clarification orders would be to contact the Nurse Practitioner either via telephone or text message. The Unit Manager elaborated that the Nurse Practitioner (NP) was typically quick to provide clarification orders and the orders should always be immediately corrected in the Electronic Medical Record (EMR). The Unit Manager stated since the facility did not have a Unit Manager at the time these orders were entered she believed the Assistant Director of Nursing (ADON) or a MDS Nurse would have been responsible for checking all new admission orders on the day

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following admission to the facility. The Unit Manager explained she was unsure how the clarifications were missed or how the NP communicated the clarifications to the staff on 3/9/21 when the chart was reviewed for clarification as requested by the pharmacy and was unsure if anyone reviewed the progress notes for missed orders.

An interview with Nurse #3 on 3/23/21 at 3:15 PM revealed she was an agency nurse, and this was her first shift to care for Resident #26. Nurse #3 reviewed the diagnoses attached to Resident #26's Buspirone, Levothyroxine, Mirtazapine, Olanzapine, Omeprazole, and Sucralfate and stated she believed them to be inappropriate and that she would have clarified these orders if she had noticed them on a resident she provided medications. Nurse #3 indicated she would call the ADON for instructions on obtaining a clarification if she noticed these medication orders were incorrect.

An interview with Nurse #5 on 3/23/21 at 3:20 PM revealed she was a nurse on the second shift. Nurse #5 reviewed Resident #26's physician orders and stated the diagnoses attached to Resident #26's Buspirone, Levothyroxine, Mirtazapine, Olanzapine, Omeprazole, and Sucralfate appeared to be incorrectly entered. She stated if she had took the orders on admission, she would have contacted the nurse at the hospital who gave her report for clarification and then if she was unable to obtain clarification from the discharging facility, she would contact the Unit Manager, ADON, DON, or facility's NP for the needed clarifications.

An interview with the ADON on 3/23/21 at 3:45

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PM revealed she had been the ADON for approximately 3 months. The ADON stated all orders should be clarified on admission from the hospital and then approved by an inhouse provider (physician or NP). She explained she would expect staff to obtain clarification orders for all admission orders to include appropriate diagnoses for their indicated use. The ADON elaborated to say she was unsure if anyone reviewed medical provider notes for potentially missed physician orders that were transcribed in the note.

An interview with the MDS Nurse #1 and MDS Nurse #2 on 3/23/21 at 3:55 PM revealed MDS Nurse #2 had identified the orders with inappropriate diagnoses prior to completing a 5day/Quarterly MDS dated 12/30/20 and notified the DON of the orders with diagnoses that appeared inconsistent with the indicated use. MDS Nurse's #1 and #2 revealed they had both notified the DON that the orders had not been clarified and corrected when they were working on completing a sequential quarterly MDS dated 1/21/21. Both stated the reason they notified the DON was because they were not able to make modification to orders. MDS Nurse #1 and MDS Nurse #1explained they were not sure if anyone reviewed physician progress notes to verify if any orders written in the progress had potentially been missed in communication.

An interview with the Medical Records Director on 3/23/21 at 4:05 PM revealed she received all physician progress notes in the facility directly via email format and was required to scan each note into the electronic medical record (EMR) within 24 hours. She acknowledged she does not review any progress notes in the facility for missing

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orders or clarifications prior to scanning the documents into the EMR.

An interview with the Pharmacy Consultant on 03/24/21 at 10:19 AM revealed she had reviewed Resident #26's EMR on 12/28/20 and again on 2/25/21 and forwarded her recommendations for the chart to be reviewed for appropriate supporting diagnoses for medications ordered. The Pharmacy Consultant indicated after her first review she forwarded her recommendations for Resident #26 directly to the DON. She stated despite the fact she reviewed all resident orders monthly she does not send repeat pharmacy recommendations sooner than approximately every 60 days to allow the facility ample time to correct all concerns. The Pharmacy Consultant explained if a recommendation was life threatening, she would direct her concerns to the provider immediately.

An interview with the NP on 3/25/21 at 3:07 PM revealed she had not received notification following the initial pharmacy recommendations provided to the facility in Dec 2020; but did review Resident #26's EMR and provide clarification orders for the 6 medications with inappropriate indications on 3/9/21. The NP was unsure how she communicated these clarification orders to staff on 3/9/21; however, she stated she usually communicated these through a physician communication sheet or writing clarification orders directly on the pharmacy recommendation sheets provided to her. The NP recalled including the clarifications in a progress noted dated 3/9/21. The NP followed up on all pharmacy recommendations with 4 weeks of receiving the requests. The NP indicated she expected the clarifications to be corrected in the EMR within

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F 756	Continued From page 46 24-48 hours of receiving the orders. An interview with the DON on 3/25/21 at 3:55 PM revealed she received all pharmacy recommendations via email directly from the Pharmacy Consultant. The DON indicated she is unsure why these pharmacy recommendations got overlooked in December because she oversees handling the corrections. The DON explained she expects staff to review admission orders and clarify any order without diagnoses or with inappropriate diagnoses immediately. She stated once clarification orders are obtained, she expects staff to correct them in the EMR within 24 hours. The DON further explained she was unsure if anyone in the facility reviewed the provider progress notes to ensure orders are not missed in communication because the progress notes are emailed directly to the Medical Records Director.	F 756		
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 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.	F 761		4/23/21

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F 761	Continued From page 47 §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 observation, record reviews and interviews, the facility failed to record medication refrigerator temperatures in 1 of 1 medication room reviewed for medication storage. The finding included: A review of a facility policy titled "Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles" revised 10/28/19 revealed: #11. Facility should ensure that medications and biologicals are stored at their appropriate temperatures according to the United States Pharmacopeia guidelines for temperature ranges. Facility staff should monitor the temperatures of vaccines twice a day. A review of a facility document titled "Temperature Log for Refrigerator" for March 2021 and under the heading "Monitor Temperatures Closely" revealed: #2. Record temps twice each workday. On 03/24/21 at 2:07 PM during an observation of the medication room accompanied by Nurse # 1, the refrigerator temperature log indicated, from March 01, 2021 through March 23, 2021 the refrigerator temperatures were documented one	F 761	Preparation submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set fourth on the survey report. Our plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. Licensed Nurses will be in-serviced on the facility policy "storage and expiration dating of medications, biologicals, syringes and needles" including on taking the refrigerator temperature in the medication room twice a day. If the temperature is out of range, nursing staff is to report the problem to the maintenance director. The 200 nurse (7am-7pm) and (7pm-7am) will complete the temperature log twice a day. Re-education of the facility policy "storage" and expiration, dating of medications, biologicals, syringes and needles will be added to new employee	

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F 761	Continued From page 48 time a day in the morning by the Unit Manager (UM), except for March 07, 11, 13, 19, 20, 21, 22 and 24 which had no recorded temperatures. The Nurse explained, that the temperatures were recorded one time a day in the morning by the third shift nurse. On 03/25/21 at 11:36 AM an attempt was made to interview the Unit Manager and a voice message was left. No return call was received from the Unit Manager. During a telephone interview with Nurse #2 on 03/25/21 at 2:51 PM she explained, the refrigerator temperatures were taken at the beginning of each shift by the nurse who counted the narcotics with the off going shift which was the 500-hall nurse. A telephone interview was conducted with the Director of Nursing (DON) on 03/25/21 at 4:43 PM. The DON explained the refrigerator temperatures should be taken twice a day, once on day shift and once on night shift. The DON continued to explain, that the UM was responsible to take the temperature on day shift and since there was no UM scheduled for the night shift the responsibility fell to one of the night shift nurses (did not specify which nurse). The DON stated, the system needed to be changed to where the nurse scheduled for a specific hall was responsible for checking and documenting the refrigerator temperatures in order to ensure the temperatures were taken twice a day, seven days a week.	F 761	orientation. The Director of Nursing / Designee will complete weekly audits to ensure that refrigerator temperatures are taken twice a day. An audit on refrigerator temperatures will start on 4/19/21. An audit for (5) five times a week for (4) four weeks, (3) three times a week for (4) four weeks and (2) two times a week for (4) weeks will be in place to ensure continued compliance. The 200 nurse (7am-7pm) and (7pm-7am) will complete the temperature log twice a day. The Director of Nursing / Infection Control Nurse will report results of the audits in the facility's monthly QAPI meetings.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		4/23/21

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F 880	Continued From page 49 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation,	F 880		

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F 880	Continued From page 50 depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to follow the "Enhanced Droplet Isolation" sign posted on the door of 2 of 14 residents that were on Enhanced droplet isolation (Resident #122 and Resident #129) by not donning a gown before entering the resident rooms on the quarantine unit. Additionally a staff member failed to remove her gloves and perform hand hygiene when exiting 1 of 14 residents that were on Enhanced Droplet Precuations (Resident #122). These failures occurred during a global pandemic.	F 880	Preparation submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set fourth on the survey report. Our plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. The Infection Control Nurse / Designee	

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F 880	Continued From page 51 The findings included: Review of the facility's Enhanced Droplet Isolation sign instructed staff to do the following: Before entering this room, follow the instruction below: universal masking: N95 (if available) if not surgical mask acceptable and must fully cover the nose, mouth, and chin. N95 or higher-level respirator (must be fit tested) needed when performing aerosolized procedures. Eye Protection when entering the room. Perform hand hygiene, gown, and gloves when entering room. The sign contained a picture to explain each piece of PPE. 1. Resident #122 was admitted to the facility on 03/17/21. Review of a physician order dated 03/18/21 read, droplet precautions for 14 days. Review of the Resident #122's electronic medical record revealed no record of a COVID-19 vaccination. An observation was made of Housekeeper (HK) #1 on 03/22/21 at 3:13 PM. HK#1 was observed entering room 502 where Resident #122 resided. The door to Resident #122's room contained a pink sign that read, before entering this room, follow the instruction below: universal masking: N95 (if available) if not surgical mask acceptable and must fully cover the nose, mouth, and chin. N95 or higher-level respirator (must be fit tested) needed when performing aerosolized procedures. Eye Protection when entering the room. Perform hand hygiene, gown, and gloves when entering room. The sign contained a picture to explain	F 880	provided re-education to HK#1 on 4/22/21 to wear Personal Protective Equipment (PPE) which includes the N95 mask, eye wear, gown and gloves for resident #122 and #129. Nurse#4 resigned without notice on 3/24/21. Re-Education was given to HK#1 from the Infection Control Nurse on 4/22/21 on the importance of universal masking N95 to fully cover the nose, mouth and chin, eye protection, gloves, donning/doffing and hand hygiene when entering and exiting a resident's room, with signage indicating Enhanced Droplet Contact precautions for infection control for resident #122 and #129. A Fish Bone Diagram Root Cause Analysis was conducted on 4/16/21. 1) The failure to follow the "Enhanced Droplet Isolation" sign posted on the door, by no donning a gown before entering the resident rooms on the quarantine unit and too remove their gloves, perform hand hygiene when exiting the room during a global pandemic. (2) The gowns should be worn when entering into a resident's room and removing your gloves and performing hand hygiene even when you are not providing direct care per the "Enhanced Droplet isolation" sign posted on the resident's door. The Root Cause Analysis was led by the Director of Nursing with input by the Nursing Home Administrator and Assistant Director of Infection Preventionist. The Results of the Root Cause Analysis were reviewed by the QAPI Committee on 4/16/21 were incorporated into the facility plan of correction.	

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F 880	Continued From page 52 each piece of PPE. HK#1 was noted to have on a KN95 mask, face shield and gloves. HK #1 entered Resident #122's room without donning a gown as instructed on the enhanced droplet isolation sign on the door. She was observed sweeping the floor and moving surfaces to sweep under them. HK#1 was observed to move the bedside table to sweep under and around it, she was observed pulling the door so she could sweep behind the door, she was observed to grab the side rails of the bed while sweeping under the bed. Once HK #1 had swept Resident #122's room she exited the room with the broom in her gloved hands and began sweeping the carpeted hallway in front of room 502 and continued down the hallway with the same gloved hands that she touched surfaces in Resident #122's room with. HK #1 did not remove her gloves and sanitize or wash her hands before moving into the hallway and sweeping. An interview was conducted with HK #1 on 03/22/21 at 3:16 PM. HK #1 stated that she had been educated by the facility staff that she was to always wear her KN95 mask and her face shield. She stated that if the resident room had a pink sign on the door telling her to put on a gown then she would do so. HK#1 stated that she knocked on Resident #122's door and entered the room without paying attention to the sign on the door and entered the room without donning a gown. HK #1 further stated that she had been trained that when she exited a resident room to always remove her gloves and use hand sanitizer or wash her hands. HK #1 added she just got busy and wrapped up in getting her assignment done that she forgot to remove her gloves and use hand sanitizer before going out into the hallway to finish sweeping.	F 880	On 4/16/21 the Root Cause Analysis indicated the reason for failure occurred because of Staff non-compliant. Staff didn't understand the importance of wearing full PPE and hand hygiene in the resident's room and before exiting the resident's room on a quarantine unit. Staff did not understand the difference with wearing PPE when providing direct care or indirect care when a "Enhanced Droplet Isolation" sign was on the door. Staff did not look at the door for the sign showing "Enhanced Droplet Precaution" and Staff did not want the food to be cold by wearing full PPE. The Director of Nursing and the Assistant Director of Nursing Infection Preventionist will provide an attestation that an in-service was completed. All residents have the potential to be affected. No additional issues were identified. An audit was conducted on 4/23/21 to identify any issues with performing ADL care and cleaning of rooms. No addition issues were identified. Staff will discard all PPE prior to exiting the resident's rooms and complete hand hygiene. On 4/15/21 the Director of Nursing / Infection Control Nurse provided re-education to Resident Care Specialist (Certified Nursing Assistant), Nurses, Therapists, Department Heads, Housekeepers/Laundry Department and	

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F 880	Continued From page 53 An interview was conducted with the Assistant Director of Nursing (ADON) on 03/24/21 at 11:13 AM. The ADON confirmed that she was also the facility's infection control preventionist and she was responsible for educating all the staff on good infection control practices. The ADON stated that the comprehensive infection control education was provided to all staff and all departments including housekeeping. She further explained that she was responsible for placing the pink enhanced droplet isolation sign on each of the resident room doors on the quarantine unit and the staff were expected to follow the sign on the door and apply the correct personal protective equipment (PPE) before entering the resident room. The ADON also stated that HK #1 should have removed her gloves and used hand sanitizer or washed her hands before exiting Resident #122's room and continuing out in the hallway. An interview was conducted with the Administrator on 03/25/21 at 11:47 AM. The Administrator stated that all staff should be following the sign on the door and applying the PPE that was required. All staff have been educated and if they had a question, they should ask the nurse on the unit. An interview was conducted with Director of Nursing (DON) #1 on 03/25/21 at 3:55 PM. DON #1 stated that all staff had been educated numerous times on the PPE that was required on the quarantine hall and the COVID hall by the ADON. She stated that they placed the pink enhanced droplet isolation sign on the resident rooms that required isolation and the sign directed the staff which PPE they should wear.	F 880	Dietary Department with emphasis on wearing proper PPE and re-education of infection control principles with emphasis on hand hygiene with enhanced droplet contact precautions for infection control on standard / transmission based precautions, hand hygiene and PPE. Effective on 4/23/21 the DON / ADON Infection Preventionist/ Designee will provide re-education of all staff including agency during new employee orientation. The Infection Control Nurse / Designee will conduct infection control audits (3) times a week for (4) four weeks, then (2) times a week for (4) four weeks, then (1) time a week for 4 weeks or until compliance has been determined on wearing proper PPE and hand hygiene procedures with direct resident contact which includes enhanced droplet contact precautions for infection control. The Director of Nursing / Infection Control Nurse will report results of the audits in the facility's monthly QAPI meetings.	

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DON #1 stated that before HK #1 entered Resident #122's room she should have donned a gown and when she exited the room, she should have removed her gloves and uses hand sanitizer or washed her hands as they have been trained to do.

2. Resident #129 was admitted to the facility on 03/12/21.

Review of a physician order dated 03/15/21 read, droplet precautions for 14 days.

Review of Resident #129's medical record revealed no record of a COVID-19 vaccination.

An observation of Nurse #4 was made on 03/24/21 at 10:07 AM. Nurse #4 was observed entering resident room 507 where Resident #129 resided. Resident #129's door contained a pink enhanced droplet isolation sign that read, before entering this room, follow the instruction below: universal masking: N95 (if available) if not surgical mask acceptable and must fully cover the nose, mouth, and chin. N95 or higher-level respirator (must be fit tested) needed when performing aerosolized procedures. Eye Protection when entering the room. Perform hand hygiene, gown, and gloves when entering room. The sign contained a picture to explain each piece of PPE. Nurse #4 had a KN95 mask, face shield and gloves in place, when entering Resident #129's room, she did not don a gown. Nurse #4 was observed to administer medications to Resident #129. Once Resident #129 had taken her medications she asked Nurse #4 for something for her productive cough that she had. Nurse #4 used hand sanitizer on the wall and exited the room. A few minutes later

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Nurse #4 returned to Resident #129's room again in a KN95 and face shield but again did not don a gown. She told Resident #129 that it was not yet time for her cough medicine. While Nurse #4 was in the room she picked up a suction catheter that was lying on the floor and discarded it in the trash can and then exited the room. Both times that Nurse #4 entered Resident #129's room she failed to don a gown as instructed by the sign on the door.

An interview was conducted with the Assistant Director of Nursing (ADON) on 03/24/21 at 11:13 AM. The ADON confirmed that she was also the facility's infection control preventionist and she was responsible for educating all the staff on good infection control practices. The ADON stated that the comprehensive infection control education was provided to all staff and all departments. She further explained that she was responsible for placing the pink enhanced droplet isolation sign on each of the resident room doors on the quarantine unit and the staff were expected to follow the sign on the door and apply the correct personal protective equipment (PPE) before entering the resident room. The ADON indicated that Nurse #4 should have donned a gown before entering Resident #129's room.

An interview was conducted with Nurse #4 on 03/24/21 at 3:37 PM. Nurse #4 confirmed that Resident #129 in room 507 was under enhanced droplet isolation and had a sign on her door stating which personal protective equipment (PPE) should be worn when entering the room. Nurse #4 confirmed that earlier on her shift she had gone into Resident #129's room to administer her medications and to take her blood pressure and she did not don a gown. She further

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explained that if she was performing a dressing change, she would apply a gown. Nurse #4 also stated that generally if the resident had an isolation sign on the door then she should apply the correct PPE including a gown. Nurse #4 could not say why she did not don a gown before entering Resident #129 ' s room earlier on her shift but did confirm that she should have applied the gown as instructed by the sign on her door.

An interview was conducted with the Administrator on 03/25/21 at 11:47 AM. The Administrator stated that all staff should be following the sign on the door and applying the PPE that was required. All staff have been educated and if they had a question, they should ask the nurse on the unit.

An interview was conducted with Director of Nursing (DON) #1 on 03/25/21 at 3:55 PM. DON #1 stated that all staff had been educated numerous times on the PPE that was required on the quarantine hall and the COVID hall by the ADON. She stated that they placed the pink enhanced droplet isolation sign on the resident rooms that required isolation and the sign directed the staff which PPE they should wear. DON #1 stated that before Nurse #4 entered Resident #129 ' s room she should have donned a gown as they have been trained to do.