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	345377	A. BUILDING _____ B. WING _____	C 04/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAST CAROLINA REHAB AND WELLNESS	2575 W 5TH STREET GREENVILLE, NC 27834

(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 4/5/21 through 4/13/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #MTEO11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint survey was conducted from 4/5/21 through 4/13/21. Immediate Jeopardy was identified at: CFR 483.25 at tag F686 at a scope and severity (J) The tag F686 constituted Substandard Quality of Care. Immediate Jeopardy began on 6/25/2020 and was removed on 4/12/21. An extended survey was conducted. 11 of the 23 complaint allegations were substantiated resulting in deficiencies.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or	F 550		5/7/21

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

Electronically Signed | 05/02/2021

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F 550	Continued From page 1 her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to treat a resident in a dignified manner by leaving a resident uncovered with the door open for a dependent resident (Resident #59) and standing over three residents while assisting with meals (Resident #15, Resident #50 and Resident #3) for 4 of 6 residents reviewed for dignity.	F 550	1. A. Resident #59's gown was retied to ensure that it was properly fitting and not exposing the resident. Resident #59's bedding was also pulled up to prevent any possible exposure. B. A chair was placed in resident #11's room to ensure that the resident could be fed at eye level when she is in bed.	

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F 550	Continued From page 2 The findings included: 1. Resident #59 was admitted to the facility on 11/7/11 with diagnoses that included dementia. The quarterly Minimum Data Set (MDS) assessment dated 3/14/21 indicated Resident #59 was in a persistent vegetative state. She was assessed as dependent for all activities of daily living including bed mobility, dressing, toilet use, personal hygiene, and bathing. During an observation on 4/6/21 at 9:54 AM Resident #59 was in bed with her gown bunched up around her waist with her midriff exposed. The top inch of her brief was exposed. Her room door was open. During an observation on 4/6/21 at 10:31 AM Resident #59 was in bed with her gown bunched up around her waist with her midriff exposed. Her room door was open. During an observation on 4/6/21 at 11:50 AM Resident #59 was in bed with her gown bunched up around her waist with her midriff exposed. Her room door was open. During an observation on 4/6/21 at 1:00 PM Resident #59 was in bed with her gown and bed linens pulled up to her waist. An interview was conducted with Resident #59 ' s responsible party who stated Resident #59 was a very modest and dignified person prior to her stroke. She stated Resident #59 would not like to be exposed to people walking by in the hallway. During an observation on 4/7/21 at 2:23 PM Resident #59 was observed lying in bed with her	F 550	C. The CNA's will be inserviced on making sure to remain seated at eye level when assisting a resident with feeding. D. A chair was placed in resident #3's room to ensure that the resident could be fed at eye level when she is in bed. 2. Other resident's were observed within the facility to ensure that no other residents were at risk for being exposed due to clothing or bedding issues. 3. The facility nursing staff will be inserviced on resident rights/dignity in regards to exposure and dignity while being fed. The staff will be instructed to make sure that residents are not exposing themselves and to make sure that when they are assisting a resident with feeding to make sure that they do so while they are sitting down in a chair, to make sure to assist the resident while they are at eye level. This in-service will be completed by 5-7-2021. 4. An audit will be performed by the DON or their designee to ensure that (1) residents are not exposed while they are in their room/bed and (2) residents are being fed at eye level and that the staff is not standing over a resident while they are assisting with feeding. This audit will take place weekly x 4 weeks and then monthly x 3 months. 5. The results of these audits will be taken to the monthly QA&A meetings to	

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gown untied at the neck and the top of her gown down around her upper arms. The gown fell approximately one inch above her breasts.

An interview and observation were conducted with Nurse # 6 on 4/7/21 at 2:34 PM. Nurse #6 stated Resident #59 ' s gown should be tied at the neck and on her shoulders to ensure dignity. She tied the gown around Resident #59 ' s neck. Nurse #6 stated Resident #59 is unable to move independently and was unsure how Resident #59 ' s gown became untied.

During an interview with Nurse Aide #2 on 4/7/21 at 2:38 PM she stated she bathed and dressed Resident #59 on 4/7/21. NA #2 stated she believed the gown was tied securely. She stated she checks on the resident every two hours. NA #2 indicated she was unaware how Resident #59 ' s gown became untied because she stated Resident #59 is unable to move.

An interview was conducted with the Director of Nursing on 4/9/21 at 11:30 PM who indicated Resident #59 clothing and bedding should be placed in a way to preserve her dignity.

2. Resident #11 was admitted to the facility on 8/31/18 with diagnoses that included dementia.

The quarterly Minimum Data Set (MDS) assessment dated 1/24/21 indicated Resident 11 ' s cognition was severely impaired with unclear speech. Resident #11 was assessed as having no behaviors. She required limited assistance with eating. She was dependent for bed mobility, toilet use, personal hygiene, and bathing.

An interview was attempted with Resident #11 on

ensure that residents are not exposed while in their room/bed and that staff who are assisting residents with feedings are not standing over the resident while doing so.

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4/7/21 at 1:15 PM. She was unable to be interviewed.

During an observation on 4/7/21 from 12:32 PM until 12:40 PM Resident #11 was in bed being fed by Nurse Aide (NA) #5 who was standing next to the resident ' s bed. During the meal observation NA #1 continued to stand over Resident #11 as she fed her.

During an interview with Nurse Aide #5 on 4/7/21 at 12:42 PM she indicated she was unaware that residents should be fed at eye level. She stated there was no chair in the room, so she was unable to sit down.

An interview was conducted with the Director of Nursing on 4/8/21 at 11:17 AM who stated that residents should be fed while at eye level. She indicated Nurse Aide #5 should have fed Resident #11 while sitting.

3. Resident #50 was admitted to the facility on 7/31/12 with diagnoses that included dementia.

The quarterly Minimum Data Set (MDS) assessment dated 3/7/21 indicated Resident #50 ' s cognition was moderately impaired. Resident #50 was assessed as having no behaviors. She required extensive assistance with bed mobility. She was dependent for dressing, toilet use, personal hygiene, and bathing.

An interview was attempted with Resident #50 on 4/7/21 at 1:18 PM. She was unable to be interviewed.

During an observation on 4/7/21 from 12:30 PM until 12:55 PM Resident #50 was in bed being

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assisted by Nurse Aide (NA) #6 who was standing next to the resident ' s bed. During the meal observation NA #6 was observed to be sitting when the resident was feeding herself. NA #6 would return to a standing position to assist Resident #50 frequently during the observation.

During an interview with Nurse Aide #6 on 4/7/21 at 1:05 PM she stated residents should be fed while sitting down. She stated because of the height of Resident #50 ' s bed she had to stand to feed her. NA #6 stated her arms are very short.

An interview was conducted with the Director of Nursing on 4/8/21 at 11:17 AM who stated that residents should be fed while at eye level. She indicated Nurse Aide #6 should have fed Resident #50 while sitting.

4. Resident #3 was admitted to the facility on 07/31/2014 with diagnoses including vascular dementia.

A review of the most recent minimum data set (MDS) assessment for Resident #3 dated 03/28/2021 indicated she was moderately impaired for daily decision making. It further indicated Resident #3 required the limited assistance of one person to eat.

A review of a care plan focus area for Resident #3 initiated on 12/29/2020 and revised on 03/30/2021 indicated Resident #3 had an activities of daily living (ADL) performance deficit related to dementia. The goal was for Resident #3 to maintain her current level of function through the next review. Interventions included Resident #3 was able to feed herself with tray set-up.

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On 04/08/2021 at 8:45 AM Nurse #6 was observed standing at the bedside of Resident #3 assisting her to eat her breakfast. An interview with Nurse #6 at that time indicated Resident #3 sometimes needed help eating her meals. Nurse #6 went on to say she should sit down when assisting Resident #3 to eat but there hadn't been a chair in the room.

On 04/08/2021 at 1:12 PM PM Nurse #6 was observed standing at the bedside of Resident #3 assisting her to eat her lunch.

On 04/08/2021 at 1:14 PM the assistant director of nursing (ADON) was observed to enter Resident #3's room and provide a chair to Nurse #6. Nurse #6 was then observed to sit down and assist Resident #3 with the rest of her meal.

On 04/08/2021 at 1:30 PM an interview with the ADON indicated she brought Nurse #6 a chair because staff should be sitting down when assisting residents to eat. She stated this provided residents with a more dignified dining experience. The ADON went on to say standing over a resident while assisting them to eat could make the resident feel rushed.

On 04/08/2021 at 11:17 AM an interview with the director of nursing (DON) indicated staff should be seated and at eye level with residents when assisting them to eat. She stated this showed respect for residents and provided them with a dignified experience.

On 04/12/2021 at 2:59 PM a telephone interview with the administrator indicated it was better for staff to sit down when assisting a resident with their meal.

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F 565 SS=D	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on staff and resident interviews the facility	F 565	1. The dietary manager went to resident	5/7/21

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F 565	Continued From page 8 failed to resolve a grievance voiced by a resident council member during individual meetings held during the COVID-19 pandemic for 1 of 1 resident council grievance reviewed (Resident #18) The findings included: An interview with the Administrator on 4/6/21 at 4:45 PM revealed the Activities Director had been going to members of the Resident Council during the last six months to relay information and allow individual council members to express concerns. He stated that there were no resident council minutes done. An interview was conducted with the Activities Director on 4/7/21 at 8:54 AM who stated there had not been any formal resident council meetings conducted since she began her employment with the facility in July 2020. She reported she would go around to different residents who were previously involved with Resident Council to discuss any issues or concerns. The Activities Director stated there were few concerns expressed. She did state Resident #18 expressed some concerns about food in approximately March. The Activities Director stated she informed the Dietary Manager. She stated she did not complete a grievance form or follow up with members of the resident council or Resident #18. The Activities Director indicated she was not sure if the concern was resolved. She stated she did not know a grievance form needed to be completed or the process for resident council grievances. An interview was conducted with Resident #18 on 4/7/21 at 10:14 AM who stated she recalled voicing concern to the Activities Director about	F 565	#18 to speak to her about the sandwiches that the facility provides. 2. No other grievances that have been expressed by the resident council group had any outstanding issues that needed resolving. 3. The activities director was inserviced on the proper way to handle any grievances that they received during a resident council meeting. This in-service will be complted by 5-7-2021. 4. A audit will be performed by the Administrator or their designee to ensure that any grievances that are expressed during a resident council meeting are followed up on timely and that the resident receives a resolution. This audit will be performed monthly x 4 months. 5. The results of this audit will be taken to the monthly QA&A meetings to ensure that any grievance that was expressed during a resident council meeting was resolved and that the resident received their resolution.	

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F 565	Continued From page 9 the sandwiches served at the facility. She stated previously the sandwiches provided would have a label with the date prepared on them. Resident #18 stated the sandwiches provided no longer were labeled with the date prepared and she wanted to ensure they were prepared the same day they were served. Resident #18 stated she never received a response. She stated the sandwiches are not labelled. An interview was conducted with the Administrator on 4/9/21 at 11:45 AM who indicated a grievance should have been completed for Resident #18's grievance.	F 565		
F 567 SS=E	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on	F 567		5/7/21

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resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund.
(B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund.
This REQUIREMENT is not met as evidenced by:
Based on staff and resident interviews and record review the facility failed to provide access to resident funds during the weekend for 2 of 2 residents reviewed for personal funds. (Resident #26, Resident #33)

Findings Included:

1. Resident #26 was admitted to the facility on 6/21/28.

A review of Resident #26's minimum data set assessment dated 2/8/21 revealed he was cognitively intact.

During an interview on 4/5/21 at 10:41 AM Resident #26 stated there was no way to get to his money on the weekends if he wanted any because it was locked in the business office and no staff had that key over the weekends. He

1. Resident #26 and #33 were informed that if they would like to receive money from their trust account on the weekends that they would just have to go see the receptionist.

2. Other residents in the facility will be notified that they can receive money on the weekends from their trust account by going to see the receptionist.

3. The business office manager and the receptionist were inserviced that residents can get money from their trust account on the weekend.

4. An audit will be performed by asking those residents who regularly access their trust fund accounts to see if they asked for money on the weekend and if they

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stated he would have to ask for his money on Friday or wait until Monday. He concluded he would like to have it available to him on the weekends.

During an interview on 4/7/21 at 4:35 PM the Business Office Manager stated residents must ask for their money on Friday or Monday as they do not have access to their money on the weekends. She further stated there were no way for residents to have access to their money on the weekends as the money is kept in the business office which is locked on the weekends and the weekend staff did not have access to those funds. The Business Office Manager stated Resident #26 had an account with the facility. She concluded the residents know to ask for their weekend money on Friday.

During an interview on 4/7/21 at 4:39 PM Nurse #3 stated he worked weekends. He concluded they told residents to ask for money on Friday or wait until Monday as the weekend staff would not provide access to their money on the weekends because it was locked up.

During an interview on 4/7/21 at 4:45 PM Nurse #4 stated she worked weekends. She concluded residents were not able to access money on the weekends.

During an interview on 4/7/21 at 4:51 PM the Administrator stated they used normal banking hours and did not leave it open on the weekend for residents to have access to their funds. He further stated it had always been that way and the only bank is in the dead heart of Greenville and there would be no way to replenish if all the residents asked to withdraw their money so they were able to receive it on that weekend day. This audit will be performed by the Administrator or their designee. This audit will be performed weekly x 4 weeks and then monthly x 3 months.

5. The results of these audits will be taken to the monthly QA&A meeting to ensure that the residents are able to access their trust funds on the weekend.

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EAST CAROLINA REHAB AND WELLNESS	2575 W 5TH STREET GREENVILLE, NC 27834

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F 567	Continued From page 12	F 567		

let the residents know they would need to get their weekend money out on Friday and some residents just used their debit card or credit card.

2. Resident #33 was admitted to the facility on 9/24/14.

A review of Resident #33's minimum data set assessment dated 2/14/21 revealed he was assessed as cognitively intact.

During an interview on 4/5/21 at 10:27 AM Resident #33 stated he had to ask for money on Friday as it was not available to him on the weekends if he wished to have money over the weekend. He concluded he would like to have money available to him on the weekends.

During an interview on 4/7/21 at 4:35 PM the Business Office Manager stated residents must ask for their money on Friday or Monday as they do not have access to their money on the weekends. She further stated there were no way for residents to have access to their money on the weekends as the money is kept in the business office which is locked on the weekends and the weekend staff did not have access to those funds. The Business Office Manager stated Resident #33 had an account with the facility. She concluded the residents know to ask for their weekend money on Friday.

During an interview on 4/7/21 at 4:39 PM Nurse #3 stated he worked weekends. He concluded they told residents to ask for money on Friday or wait until Monday as the weekend staff would not provide access to their money on the weekends because it was locked up.

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F 567	Continued From page 13 During an interview on 4/7/21 at 4:45 PM Nurse #4 stated she worked weekends. She concluded residents were not able to access money on the weekends. During an interview on 4/7/21 at 4:51 PM the Administrator stated they used normal banking hours and did not leave it open on the weekend for residents to have access to their funds. He further stated it had always been that way and the only bank is in the dead heart of Greenville and there would be no way to replenish if all the residents asked to withdraw their money so they let the residents know they would need to get their weekend money out on Friday and some residents just used their debit card or credit card.	F 567		
F 570 SS=C	Surety Bond-Security of Personal Funds CFR(s): 483.10(f)(10)(vi) §483.10(f)(10)(vi) Assurance of financial security. The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide a surety bond or similar protection for 71 of 71 residents with funds deposited in the resident trust account. Findings included: During an interview on 4/8/21 at 11:38 AM the Owner of the facility stated he did not currently have proof of surety bond protection available for review. He concluded he was working on providing the surety bond documentation.	F 570	1. The surety bond for the current year was obtained and is current. A surety bond for the current year was obtained on 4-9-2021. 2. There are no other issues that would affect other residents within the facility since the surety bonds covers all of the resident trust accounts. 3. The business office manager was inserviced on making that the surety bond	5/7/21

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F 570	Continued From page 14 During an interview on 4/9/21 at 8:31 AM the Administrator stated the cooperate office of the facility was responsible for renewing the surety bond for the facility. He further stated he was unaware if or when any renewal dates were for the surety bond. A record review of the facility trust account on 4/9/21 revealed 71 residents had a total of $165,638.41 in the trust account. During an interview on 4/9/21 at 9:46 AM the Business Office Manager stated 71 residents currently had funds deposited in the trust account. The current balance of the trust account was $165,638.41. She further indicated the corporate office oversaw the surety bond protection and she was unaware of the information. During an interview on 4/13/21 at 1:05 PM the Administrator stated he did not have the surety bond available for review however he would forward it to the surveyor if he was able to acquire it prior to the CMS 2567 being completed.	F 570	is renewed yearly and that the facility receives a copy of the bond. This in-service will be completed by 5-7-2021. 4. An audit will be performed on a yearly basis to ensure that the surety bond is kept current. The audit will be performed by the Administrator or their designee. 5. The results of this audit will be taken to the facility monthly QA&A meeting to ensure that the surety bond is kept current.	
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	F 578		5/7/21

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F 578	Continued From page 15 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 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 ensure that the resident's elected advance directive matched with the physician's order in the electronic health record and hard chart for 3 of 3 residents reviewed for advance directive (Resident #38, #53, and #65)	F 578	1. Residents #38, #53 and #65 had physician order□s for code status placed into their electronic medical records to indicate whether the resident was a DNR or full code 2. An initial audit was performed on all	

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F 578	Continued From page 16 Findings included: 1. Resident #38 was admitted to the facility on 9/22/15 and most recent reentry to the facility was on 12/21/20. She had diagnoses which included dementia. The most recent Minimum Data Set dated 2/21/20 indicated Resident #38 was moderately cognitively impaired and was coded as total dependence for activities of daily living. Resident #38's hard copy chart was reviewed. A yellow "Do not resuscitate (DNR) form signed by the physician dated 12/15/20 was noted as well as a doctor's order for the resident to be DNR dated 12/15/20 signed by the physician. Resident #38's electronic records were reviewed. There was no physician's order for code status (the type of emergency treatment the resident would receive if their heart or breathing stopped) to indicate whether the resident was a DNR or a full code in the electronic records. An interview with the Director of Nursing (DON) on 4/6/21 at 10:09 AM revealed Resident #38 should have a physician's order for code status in the electronic record. She confirmed the staff should be able to locate the resident's code status in the electronic health record. The DON stated the nurse is responsible to ensure the code status was entered in to the electronic health record. She stated during a medical emergency the resident's code status could be located either in the hard chart, which was located in a locked room at the nurses' station or in the electronic health record.	F 578	residents in the facility to ensure that they had a physician□s order for code status placed in their electronic medical records. 3. The nurses were inserviced to inform them that each resident needed a physician order for code status in the electronic medical record. The process for entering the code status order was explained to the nurses. This in-service will be completed by 5-7-2021 4. An audit will be performed by the DON or their designee to ensure that each resident has a physician□s order for code status placed in their electronic medical record. This audit will be completed weekly x 4 weeks and then monthly x 4 months. 5. The results of this audit will be taken to the facility monthly QA&A meeting to ensure that each resident has a physician□s order for code status placed in their electronic medical record.	

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An interview with the Administrator on 4/12/21 at 12:05 PM revealed that all residents should have a physician's order for code status in the electronic record.

2. Resident #53 was admitted to the facility on 3/03/21 with diagnoses which included fusion of the spine.

The most recent Minimum Data Set dated 3/10/21 indicated Resident #53 was cognitively intact and was coded as extensive assistance or total dependence for most activities of daily living.

Resident #51's hard copy chart was reviewed. A yellow "Do not resuscitate (DNR) form signed by the physician dated 3/03/21 was noted as well as a doctor's order for the resident to be DNR dated 3/03/21 signed by the physician.

Resident #51's electronic records were reviewed. There was no physician's order for code status (the type of emergency treatment the resident would receive if their heart or breathing stopped) to indicate whether the resident was a DNR or a full code in the electronic records.

An interview with the Director of Nursing (DON) on 4/06/21 at 10:20 AM revealed Resident #53 should have a physician's order for code status in the electronic record. She confirmed the staff should be able to locate the resident's code status in the electronic health record. The DON stated the nurse is responsible to ensure the code status was entered in to the electronic health record. She stated during a medical emergency the resident's code status could be located either in the hard chart, which was

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located in a locked room at the nurses' station or in the electronic health record.

An interview with the Administrator on 4/12/21 at 12:05 PM revealed that all residents should have a physician's order for code status in the electronic record.

3. Resident #65 was admitted to the facility on 1/5/18 with diagnoses that included chronic obstructive pulmonary disease.

Review of Resident #65's most recent Minimum Data Set (MDS) assessment, dated 1/31/21 indicated she was cognitively intact. Resident #65 required supervision with most activities of daily living.

Resident #65's hard copy chart was reviewed. A yellow "Do not resuscitate (DNR) form signed by the physician dated 7/21/18 was noted as well as a doctor's order for the resident to be DNR dated 7/21/18 signed by the physician.

Resident #65's electronic records were reviewed. There was no physician's order for code status (the type of emergency treatment the resident would receive if their heart or breathing stopped) to indicate whether the resident was a DNR or a full code in the electronic records.

An interview with the Director of Nursing (DON) on 4/06/21 at 10:20 AM revealed Resident #65 should have a physician's order for code status in the electronic record. She confirmed the staff should be able to locate the resident's code status in the electronic health record. The DON stated the nurse is responsible to ensure the code status was entered in to the electronic health record. She stated during a medical

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F 578	Continued From page 19 emergency the resident's code status could be located either in the hard chart, which was located in a locked room at the nurses' station or in the electronic health record. An interview with the Administrator on 4/12/21 at 12:05 PM revealed that all residents should have a physician's order for code status in the electronic record.	F 578		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the	F 580		5/7/21

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F 580	Continued From page 20 resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and responsible party interviews, the facility failed to notify the physician immediately for a bruise of unknown origin (Resident #38) and failed to notify the resident's responsible party of nausea, vomiting and as needed anti-nausea medication (Resident #59) for 2 of 3 residents reviewed for notification of change. Findings include: 1. Resident #38 was admitted to the facility on 9/22/15 and her most recent reentry to the facility was on 12/21/20. She had diagnoses which included dementia and right above the knee amputation.	F 580	1. The nurses who took care of resident #38 and #59 were inserviced on the importance of calling the physician and responsible party for changes in resident condition in a timely manner. 2. All nurses were inserviced regarding calling a resident□s physician and responsible party for changes in a resident□s condition. The inservice also reminded the nurses to make sure to make the notifications in a timely manner. This in-service will be completed by 5-7-2021. 3. An audit will be performed by the	

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F 580	Continued From page 21 The most recent Minimum Data Set dated 11/20/20 indicated Resident #38 was moderately cognitively impaired and was coded as total dependence for activities of daily living. Review of Resident #38's hospital records dated 1/24/21, read in part that resident was seen for a bruise on her forehead. She had a computed tomography scan (CT) of her head that did not show signs of injury and she is stable to go back to her living facility. An interview with Nurse #8 on 4/07/21 at 4:25 AM revealed she noticed a bruise on Resident #38's left forehead at approximately 4:30 AM or 5:00 AM on 1/24/21. She verified she did not contact the physician. She stated she waited until the day shift nurse, Nurse #9, arrived and requested she reassess Resident #38. An interview with Nurse #9 on 4/08/21 at 4:28 PM revealed she reassessed Resident #38 on 1/24/21 and sent her to the hospital due to observation of a bruise on her left forehead. She stated she contacted the physician after the resident had been transported to the hospital. An interview with the Director of Nursing (DON) on 4/08/21 at 12:29 PM revealed she was aware of Resident #38's bruise and transfer to the hospital for evaluation. She stated the nurse should have contacted the physician when she first noticed it. An interview with the Administrator on 4/12/21 at 12:05 PM revealed that Nurse #8 should have notified the physician when she first observed the bruise on Resident #38's forehead.	F 580	DON or their designee to ensure that the physician and responsible party were notified timely regarding changes in a resident□s condition. This audit will be performed weekly x 4 week and then monthly x 4 months. 4. The results of this audit will be taken to the facility monthly QA&A meeting to ensure that physician□s and responsible party□s are notified timely of changes in a residents condition.	

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2. Resident #59 was admitted to the facility on 11/7/11 with diagnoses that included dementia and dysphagia (swallowing difficulties).

The quarterly Minimum Data Set (MDS) assessment dated 3/14/21 indicated Resident #59 was in a persistent vegetative state. The assessment revealed Resident #59 received 51% or more of her nutrition and hydration through a feeding tube.

Review of a nursing progress note dated 4/8/20 written by Nurse #5 revealed Resident #59 had vomited during her tube feeding. Her feeding pump was turned off due to the vomiting. Resident #59 was given as needed Zofran (an anti-nausea medication). The note stated the physician was notified.

A telephone interview was conducted with Resident #59's responsible party on 4/6/21 at 2:32 PM who stated she was notified of any changes in Resident #59's condition only if Resident #59 was sent to the hospital. She stated she wanted to be notified of any changes in Resident #59's condition. The responsible party stated prior to the visitation restrictions due to the pandemic she was visiting Resident #59 several times each week and staff would notify her of any changes in Resident #59's condition no matter how minor. The responsible party stated there has been staff turnover and she was no longer receiving this information.

An interview was conducted with Nurse #5 on 4/8/21 at 4:37 PM who stated she could not recall the incident with Resident #59 on 4/8/20. She stated if she had contacted Resident #59's responsible party she would have documented it

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F 580	Continued From page 23 in the medical record. An interview was conducted with the Director of Nursing on 4/8/21 at 11:30 AM who stated nursing staff should have contacted Resident #59's responsible party when she had a change in condition and received an as-needed medication.	F 580		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must	F 585		5/7/21

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include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the

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F 585	Continued From page 25 provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on resident interviews, family interviews, staff interviews, and record review the facility failed to resolve grievances for 1 of 2 resident reviewed for grievances (Resident #18). The findings included: Resident #18 was admitted to the facility on 11/12/19. The Minimum Data Set (MDS) assessment dated 1/31/21, an annual assessment revealed Resident #18 was cognitively intact.	F 585	1. The facility staff were inserviced regarding the grievance resolution for resident #18 and that she should be receiving her meal trays 1st when they are being passed out since this was the resolution to a grievance filed by resident #18. 2. An initial audit of grievances filed within the last 30 days was performed to ensure that the resolutions are being followed as written.	

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F 585	Continued From page 26 An interview was conducted with Resident #18 on 4/7/21 at 10:14 AM who stated she had filed a grievance with the facility and received no response. She stated her grievance was often when she received her meals the food was cold. A grievance dated 12/1/20 revealed Resident #18 expressed a concern her food was cold when she received her tray. The corrective action on the grievance stated nursing staff would give the resident her tray first when the trays arrived on the hall. A review of a grievance reports from November 2020 through April 2021 revealed no other grievance reports filed on Resident #18's behalf. An observation was conducted 4/7/21 from 12:00 PM when the lunch trays arrived on the hall until 12:18 PM when Resident #18 received her tray. An interview was conducted with Resident #18 who stated her food was warm but it was not hot. An interview was conducted with Nurse Aide (NA) #6 on 4/7/21 at 12:32 PM who stated trays are delivered on the hall based on room numbers. She stated she was unaware of any resident who should receive her tray first. An interview with Nurse Aide (NA) #7 on 4/7/21 at 12:42 PM who stated she was unaware of any resident who should receive her tray first. An interview was conducted with the Director of Nursing on 4:28 PM. She stated the Administrator is responsible for completing the resolution section of the grievance form and	F 585	3. The facility staff were inserviced on the grievance process of the facility. This inservice also covered making to sure to follow up with the resolution to the grievance to ensure that the resolution is acceptable and being followed. This in-service will be completed by 5-7-2021. 4. An audit will be completed by the Administrator or their designee to ensure that all grievance have an acceptable resolution and that those resolutions are being followed. The audit will be performed weekly x 4 weeks and then monthly x 4 months. 5. The results of this audit will be taken to the facility monthly QA&A meeting to ensure that all grievances have an acceptable resolution and that those resolutions are being followed.	

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F 585	Continued From page 27 notifying the resident or responsible party of the resolution. She stated the intervention of Resident #18 receiving her tray first was implemented when she was residing on a different hall. The DON stated the nurse aides on her current hall were not made aware to serve Resident #18 her tray first. An interview was conducted with the Social Worker on 4/7/21 at 11:05 PM who stated the grievance form should have been completed documenting notification of the resolution of the grievance. An interview was conducted with the Administrator on 4/8/21 at 1:34 PM. He stated he had sent a notice to Resident #18's responsible party with the resolution but did not receive a response from the responsible party. He stated he believed he spoke with Resident #18 about the resolution of the grievance. He reported he did not document it on the form because Resident #18 has confusion.	F 585		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of discharge planning, hospice, preadmission screening resident review (PASSR), and pressure ulcer for 5 of 34 residents whose MDS assessments were reviewed (Resident #56,	F 641	1. A. Resident #56 MDS dated 3-14-21 was corrected to show that the resident is a long term resident with no discharge plan to return to the community B. Resident #11 MDS dated 7-28-20 was corrected to show that the resident did not	5/7/21

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Resident #11, Resident #32, Resident #220, and Resident #116).

The findings included:

1. Resident #56 was admitted to the facility on 12/11/19 with chronic obstructive pulmonary disease.

Resident #56's Minimum Data Set (MDS) assessment dated 3/14/21, a quarterly assessment revealed a discharge plan to return to the community.

An interview with the Social Worker was conducted on 4/8/21 at 11:10 AM. She reported the MDS assessment was inaccurate because Resident #56 planned to stay in the facility long-term. The Social Worker stated she was unsure how she made the error.

During an interview with the Director of Nursing on 4/9/21 at 11:30 AM she stated MDS assessments should be coded to accurately reflect resident's discharge plans.

2. Resident #11 was admitted to the facility on 8/23/16 with diagnoses that included dementia.

Resident #11's Minimum Data Set (MDS) assessment dated 7/28/20, a significant change assessment revealed hospice services were received while not a resident of the facility. The resident began receiving hospice services after her readmission to the facility after a hospitalization.

A hospital discharge summary dated 7/22/20 revealed a recommendation for a hospice referral

receive hospice services while not a resident at the facility.

C. Resident #32 MDS dated 8-19-20 was corrected to show that the resident no longer required Level II pasrr evaluations

D. Resident #220 MDS dated 3-26-21 was corrected to show that the resident met the requirements for level II pasrr status.

E. Resident #116 MDS dated 11-13-20 was corrected to show that the resident did not have a stage 2 pressure ulcer present on admission to the facility.

2. An initial audit was performed on recently completed MDS in the last quarter to ensure that (1) the discharge plan coded on the MDS is correct (2) that those residents who receive hospice care have this coded correctly (3) that passr determinations are coded correctly and (4) that pressure ulcers were coded correctly as either admitted with or facility acquired.

3. The staff that complete MDS assessments were inserviced on the importance of coding accurate information on their section of the MDS. They were informed to make sure to double check their work before submitting to ensure that the information that they entered is correct and accurate. This in-service will be completed by 5-7-2021.

4. An audit will be completed by the

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F 641	Continued From page 29 upon Resident #11's return to the facility. Review of a physician's order revealed Resident #11 was referred to hospice on 7/22/20. During an interview with MDS Nurse #2 on 4/8/21 at 4:27 PM she stated she thought Resident #11 received hospice services while in the hospital. She indicated when she reviewed the hospital discharge summary which mentioned the recommendation for hospice services, she thought the services were initiated at the hospital. After review of the discharge summary MDS Nurse #2 indicated Resident #11's assessment was coded inaccurately. During an interview with the Director of Nursing on 4/9/21 at 11:30 AM she indicated MDS assessments should be coded to accurately reflect resident's status and care received. 3. Resident #32 was admitted to the facility on 2/4/00 with diagnoses that included dementia. Review of a Halted PASRR Level Determination Notification from the North Carolina Division of Medical Assistance dated 2/11/18 revealed Resident #32 did not meet the definitions of mental llness/mental retardation and was no longer required to further Level II PASRR evaluations. Resident #32's Minimum Data Set (MDS) assessment dated 8/19/20, a significant change assessment revealed Resident #32 was coded as meeting the definition of mental illness/mental retardation and required Level II evaluations. During an interview with the Social Worker on	F 641	DON or their designee to ensure that the information entered on the MDS assessments is accurate. This audit will take place weekly x 4 weeks and then monthly x 4 months. A random sample of 3 of the recently completed MDS assessments will be audit to ensure accuracy. 5. The results of this audit will be taken to the facility monthly QA&A meeting to ensure that information entered on the MDS assessments are accurate.	

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4/8/21 at 5:30 PM she stated she was unaware that Resident #32 no longer required Level II PASRR evaluations. She stated she did not have a process to identify when residents no longer required Level II PASRR evaluations.

During an interview with the Director of Nursing on 4/9/21 at 11:30 AM she indicated MDS assessments should be coded to accurately reflect resident's status and care received.

4. Resident #220 was admitted to the facility on 3/19/21 with diagnoses that included schizophrenia.

Review of a PASRR Level II Determination Notification from the North Carolina Department of Health and Human Services dated 3/19/21 revealed Resident #220 required specialized services due to a mental illness. Resident #220's evaluation was done prior to his admission to the facility.

Resident #220's Minimum Data Set (MDS) assessment dated 3/26/21, an admission assessment revealed Resident #220 had not required a Level II PASRR evaluation for as he did not meet the definition of mental illness.

During an interview with the Social Worker on 4/8/21 at 5:30 PM she stated she stated Resident #220's MDS assessment was coded inaccurately and should have reflected his Level II PASRR status. She stated she made a coding error.

During an interview with the Director of Nursing on 4/9/21 at 11:30 AM she indicated MDS assessments should be coded to accurately reflect resident's status and care received.

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5. Resident #116 was admitted to the facility on 11/13/2020 with diagnoses including right femur (thigh) fracture.

A review of the admission 5-day minimum data set (MDS) assessment for Resident #116 dated 11/20/2020 indicated she was independent with daily decision making. It further indicated she required the total assistance of one person for bed mobility and transfers and the extensive assistance of one person for toileting. Resident #116 was at risk for pressure ulcers, had pressure relieving devices in place and had one stage 2 (shallow with a reddish base) pressure ulcer present on admission to the facility.

A review of a care plan focus area for Resident #116 initiated 11/13/2020 indicated she was at risk for pressure ulcers. The goal was for her risk for pressure ulcers to be minimized with skin interventions in place through the next review. Interventions included observe skin for open areas and report to nurse as soon as noted. This focus area was updated on 11/18/2020 to reflect the presence of a stage 2 pressure ulcer to Resident #116's sacrum (base of spine).

A review of the nursing admission assessment for Resident #116 dated 11/13/2020 indicated she had a dressing intact to her right hip surgical incision. It further indicated she had no areas of pressure injury or skin breakdown present on admission.

A review of a nursing progress note for Resident #116 dated 11/18/2020 indicated the nurse had been informed Resident #116 had an open area to her sacrum. The note went on to say the treatment nurse was notified and treatment to the

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F 641	Continued From page 32 area was initiated. On 04/09/2021 at 12:07 PM an interview with wound care nurse #1 indicated she was the facility treatment nurse. She stated she was notified on 11/18/2020 that Resident #116 had an open area to her sacrum. She further indicated this sacral wound was not present on Resident #116's admission to the facility. On 04/09/2021 at 09:27 AM an interview with MDS nurse #1 indicated she completed the pressure ulcer section of Resident #116's MDS assessment dated 11/20/2020. She stated Resident #1 did not have a stage 2 pressure ulcer present on admission to the facility and the information on the 11/20/2020 MDS assessment was incorrect. MDS nurse #1 went on to say she would correct this assessment. On 04/12/2021 at 2:59 PM a telephone interview with the administrator indicated information on resident's MDS assessments should accurately reflect their condition.	F 641		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's	F 644		5/7/21

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F 644	Continued From page 33 assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to refer a resident with a diagnosis of mental illness for a Preadmission Screening and Resident Review (PASARR) evaluation for 1 of 4 residents reviewed for PASARR. (Resident #33) Findings included: 1. Resident #33 was admitted to the facility on 9/24/14. A review of Resident #33's Minimum Data Set (MDS) assessment dated 2/14/21 revealed he was assessed as cognitively intact. He had verbal behavioral symptoms directed towards others 1 to 3 days of the look back period. A review of Resident #33's care plan dated 2/24/21 revealed he was care planned for antidepressant use related to depressive features with mood disorder. The interventions included to administer antidepressant medications as ordered by the physician and monitor for adverse reactions to antidepressant therapy and notify physician if any are identified. He was also care planned for the use of antipsychotic medications. The interventions included to administer medications as ordered by the physician, monitor for adverse effects of antipsychotic use, and	F 644	1. A level II pasrr screen was submitted by the social worker for resident #33 2. An initial audit was performed to all residents to ensure that those residents with diagnosis that would require a level II passr received a level II passr screen. 3. The social worker was inserviced on where to look for a list of new diagnosis within the electronic medical record system so that any new diagnosis entered can be evaluated to ensure that a level II pasrr screening is not missed. A new diagnosis report will be run out of point click care and reviewed in the morning department head meeting so that any new diagnosis that would required a level II pasrr screen can be discussed. This in-service will be completed by 5-7-2021. 4. A audit will be performed by the Administrator or their designee to ensure that any new diagnosis that are entered into the electronic medical record are screen to see if a level II pasrr screen needs to be requested. This audit will be performed weekly x 4 weeks and then monthly x 4 months.	

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monitor for target behaviors and notify physician if behaviors worsen or increase in frequency.

A review of Resident #33's diagnoses revealed on 1/19/21 he was diagnosed with mood disorder due to known physiological condition with depressive features. On 2/14/21 he was diagnosed with unspecified psychosis not due to a substance or known physiological condition as well as major depressive disorder.

A review of Resident #33's most recent PASARR referral on NC MUST (North Carolina Medicaid Uniform Screening Tool) with Social Worker #1 on 4/6/21 at 2:53 PM revealed his last referral for a PASARR screen was dated 3/29/2019.

During an interview on 4/6/21 at 2:54 PM Social Worker #1 stated if there was a new suspected mental illness or a new diagnosis such as depression, psychosis, and mood disorder then a new PASARR referral would be made. She stated medical records, or the nurses would let her know if there was a new mental diagnosis or change and she would then complete the referral. She stated the new diagnosis of unspecified psychosis, mood disorder, and major depressive disorder would trigger a new PASARR referral; however, she was unaware of the new diagnoses for Resident #33. She further stated she did not know why they were not discussed during the annual MDS care conference as the assessment reference date was 2/14/21. She concluded she would complete a PASARR referral at that time.

During an interview on 4/6/21 at 3:14 PM Administrator stated he was not 100% familiar with the PASARR process and was not fully aware of when a resident was to be triggered to

5. The results of this audit will be taken to the facility monthly QA&A meeting to ensure that any new diagnosis entered into the electronic medical record are reviewed for possible level II pasrr screening.

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F 644	Continued From page 35 be referred to NC MUST. He further stated if that was the process required by NC MUST and CMS (Centers for Medicare & Medicaid Services) that Resident #33's new diagnoses would require a new referral to NC MUST then Social Worker #1 should have followed the correct referral process.	F 644		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).	F 655		5/7/21

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F 655	Continued From page 36 §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to develop a baseline care plan including preadmission screening resident review (PASRR) recommendations for 1 of 4 residents reviewed for baseline care plans (Resident #220). The findings included: Resident #220 was admitted to the facility on 3/19/21 with diagnoses that included schizophrenia. Review of a PASRR Level II Determination Notification from the North Carolina Department of Health and Human Services dated 3/19/21 revealed Resident #220 required specialized services due to a mental illness. The specialized services included follow-up psychiatric services by a psychiatrist and mental health follow-up. Review of Resident #220's baseline care plan with a review date of 3/22/21 revealed no mental health needs, behavior concerns or PASRR Level II recommendations.	F 655	1. Resident #220 baseline care plan was updated to show that the resident had mental health needs, behavior concerns and a passr level II recommendation 2. All other baseline care plans were reviewed to ensure that those residents who had passr level II recommendations had this information reflected on their base line care plan. 3. The social worker was inserviced on base line care plans and ensuring that any resident with level II passr recommendations had this information included on the base line care plan. This in-service will be completed by 5-7-2021. 4. An audit will be completed by the DON or their designee to ensure that the baseline care plan for any resident with level II passr recommendations had the appropriate information listed. This audit will be completed weekly x 4 weeks and	

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F 655	Continued From page 37 During an interview with Minimum Data Set (MDS) Nurse #2 on 4/8/21 at 5:15 PM she stated the PASRR recommendations are placed on the baseline care plan by the Social Worker. During an interview with the Social Worker on 4/8/21 at 5:30 PM she stated that she does not put goals on the baseline care plan as the care plan is completed by MDS nurses. During an interview with the Director of Nursing on 4/9/21 at 11:30 AM she indicated baseline care plans should be completed to incorporate specialized services determined by PASRR Level II Determinations.	F 655	then monthly x 4 months. 6. The results of this audit will be taken to the facility monthly QA&A meeting to ensure that the base line care plans for those residents with level II pasrr recommendations included the appropriate information.	
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	F 656		5/7/21

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F 656	Continued From page 38 treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to develop a comprehensive person-centered care plan which included the use of bedrails for 1 of 2 residents (Resident #49) reviewed for bedrails and failed to implement the comprehensive person-centered care plan which included weekly skin inspections for 1 of 53 residents (Resident #166) whose care plans were reviewed. Findings included: 1. Resident #166 was admitted to the facility on 08/27/2019 with diagnoses including stroke (damage to the brain from interruption of the blood supply).	F 656	1. A. The facility was not able to complete a skin check on resident #166 since she had been discharged from the facility on 12-22-2020. B. Resident #49 had a bed rail care plan added to their comprehensive care plan. 2. A. The facility performed skin checks on all of the residents in the facility on 4-9-2020. B. Any resident who currently has bed rails on their bed had their care plans audited to ensure that a care plan was there for the use of bed rails.	

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F 656	Continued From page 39 A review of the quarterly minimum data set (MDS) assessment for Resident #166 dated 10/31/2020 indicated she was rarely or never understood. It further indicated she required the total assistance of one person for bed mobility, toileting and personal hygiene. Resident #166 was at risk for pressure ulcers and had one stage 2 (shallow with reddish base) pressure ulcer not present on admission. She had a pressure relieving device to her bed and nutrition and hydration interventions and pressure ulcer care in place. A review of the care plan for Resident #166 dated 11/03/2020 indicated a focus area of activities of daily living (ADL) performance deficit related to hemiparesis (muscle weakness) with a goal of remaining at the current level of function through the next review and interventions including weekly skin inspection. A review of a weekly skin inspection for Resident #166 dated 10/28/2020 indicated Resident #166 had a pressure injury to her sacrum (base of spine) and the treatment nurse was notified. A review of Resident #166's medical record indicated no further weekly skin inspections documented from 10/28/2020 through her discharge from the facility on 12/22/2020. On 04/06/2021 at 2:38 PM an interview with Wound Care Nurse #1 indicated she was the facility treatment nurse. She stated she was notified on 10/28/2020 that Resident #166 had an open area to her sacrum which she measured, staged and documented in her progress notes. Wound Nurse #1 went on to say she measured and documented the wound progress weekly	F 656	3. A. The facility nurses were inserviced on the completion of the weekly skin checks for all residents. The nurses were informed that the weekly skin checks were scheduled for the residents and that they were responsible for completing those skin checks. This in-service will be completed by 5-7-2021. B. The MDS nurses were inserviced on making sure that any resident that utilize bed rails had the appropriate bed care plan included in their comprehensive care plan. This in-service will be completed by 5-7-2021. 4. An audit will be completed by the DON or their designee to ensure that (1) the weekly skin checks are being performed as scheduled and (2) that those resident that utilize bed rails have the appropriate bed rail care plan included in their comprehensive care plan. These audits will be completed weekly x 4 weeks and then monthly x 4 months. 5. The results of this audit will be taken to the facility monthly QA&A meeting to ensure that the weekly skin checks are being performed and that the comprehensive care plans include bed rail care plans for those residents who utilize bed rails.	

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F 656	Continued From page 40	F 656		

from 10/28/2020 until Resident #166's discharge from the facility on 12/22/2020. She further indicated Resident #166 had not had any additional areas of skin breakdown that she was aware of. She stated she was not responsible for resident's weekly skin inspections, the floor nurse did those.

On 04/06/2021 at 2:58 PM an interview with the director of nursing (DON) indicated she could find no evidence Resident #166 had weekly skin inspections done from 10/28/2020 through 12/22/2020. She stated Resident #166 should have had these done and documented weekly to promptly identify any new areas of skin breakdown because Resident #166 was at risk.
2.Resident #49 was admitted to the facility on 10/19/2016 with the diagnoses of seizure disorder, absence of the right above knee, and absence of left leg below the knee.

A quarterly Minimum Data Set (MDS) dated 3/7/2021 revealed Resident #49 had severe cognitive impairment, required total assistance with bed mobility, transfers, was non-ambulatory and had an impairment of both upper and lower extremities. The use of bed siderails was not indicated.

A care plan with the latest review date 3/11/2021 did not include the use of siderails.

An observation on 4/5/2021 at 9:40 am revealed Resident #49 resting in the bed with bilateral three-quarter siderails in a raised and locked position.

During an interview with MDS Nurse #1 on 4/6/2021 at 3:00 pm she stated there was no plan

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F 656	Continued From page 41 for Resident #49's siderails because the siderails were for the staff. MDS Nurse #1 clarified the statement and said Resident #49's siderail was to establish perimeters . The Assistant Director of Nursing (ADON) stated on 4/8/2021 at 11:30 am the MDS Nurses was responsible for developing the care plans. The ADON said Resident #49's siderails should have been care planned. The Administrator stated during an interview on 4/9/2021 at 9:30 am if Resident #49 had something that should have been care planned it should have been on the care plan.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in	F 657		5/7/21

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F 657	Continued From page 42 disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review the facility failed to review and revise the plan of care related to discharge planning (Resident #56) and invite a resident ' s representative to a care plan meeting (Resident #59) for 2 of 8 residents reviewed for care plans. The findings included: 1. Resident #56 was admitted to the facility on 12/11/19 with chronic obstructive pulmonary disease. Resident #56's Minimum Data Set (MDS) assessment dated 3/14/21, a quarterly assessment revealed she was assessed as having moderate cognitive impairment. Review of Resident #56's most recent care plan dated 2/26/21 revealed a goal to discharge to the community. An interview with Resident #56 on 4/5/21 revealed she planned to stay in the facility long-term. An interview with the Social Worker was conducted on 4/8/21 at 11:10 AM. She reported the care plan was incorrect because Resident #56 planned to stay in the facility long-term. The social worker stated this occurred because her	F 657	1. A. Resident #56 care plan was updated to show that resident plans to stay in the facility long-term. B. The responsible party of resident #59 will be invited to all future care plan meetings 2. A. An initial audit was completed to ensure that the discharge status for all residents in the facility was accurately documented in the residents comprehensive care plan B. Going forward all responsible party□s will be contacted regarding their loved one□s care plan meeting and the social worker will document in the EMR if the RP accepted or declined the care plan invitation. 3. The social worker was inserviced on the importance of ensuring that the discharge status for all resident was correct in the comprehensive care plan and that responsible parties are contact for care plan meetings and that the invitation is document in the resident EMR. This in-service will be completed by 5-7-2021.	

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F 657	Continued From page 43 care plan was copied from the one completed last year. She indicated she was uncertain why it had not been noticed during the care plan meeting. During an interview with the Director of Nursing on 4/9/21 at 11:30 AM she stated care plans should accurately reflect resident's discharge plans. 2. Resident #59 was admitted to the facility on 11/7/11 with diagnoses that included dementia. The quarterly Minimum Data Set (MDS) assessment dated 3/14/21 indicated Resident #59 was in a persistent vegetative state. She was assessed as dependent for all activities of daily living including bed mobility, dressing, toilet use, personal hygiene, and bathing. A telephone interview was conducted with Resident #59's responsible party on 4/6/21 at 2:30 PM. She stated she had not been invited or notified of care plan meetings since visitation restrictions were put in place during the pandemic. She stated she would like to be participate in care plan meetings for Resident #59. An interview was conducted with the facility social worker on 4/6/21 at 4:12 PM who stated she was responsible for inviting resident's responsible parties to care plan meetings. She stated she could not recall if Resident #59's responsible party had been invited to the care plan meetings and could not recall if the invitation had been issued verbally over the phone or by mail. The social worker checked her records and could not verify Resident #59's responsible party had been invited to the care plan meetings. She stated that	F 657	4. An audit will be completed by the DON or their designee to ensure that (1) the comprehensive care plan includes the accurate discharge status care plan and (2) that responsible parties are being contacted regarding care plan meetings. These audits will take place weekly x 4 weeks and then monthly x 4 months. 5. The results of this audit will be taken to the facility monthly QA&A meeting to ensure that the care plans reflected the discharge status of residents correctly and that responsible parties are being contacted regarding care plan meetings.	

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F 657	Continued From page 44 copies of care plans were mailed out to resident's responsible parties after care plan meetings. She reported that if responsible parties would like to be involved in care plans it could be done via phone. The social worker indicated Resident #59's responsible party should have notified her if she would like to be part of care plan meetings as care plan meetings are held quarterly. She stated she would invite Resident #59's responsible party to the upcoming care plan meeting. During an interview with the Director of Nursing on 4/9/21 at 11:30 AM she indicated residents and responsible parties should be invited to their care plan meetings and be involved with their care.	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and staff and physician interviews the facility failed to have a resident's condition assessed by a licensed medical professional before staff moved the resident after the resident experienced a fall for 1 of 4 residents reviewed for accidents (Resident #40).	F 684	1. Resident #40 will be assessed by a licensed medical professional before being moved if resident #40 experiences a fall in the future. 2. Going forward all residents will have their condition assessed by a licensed	5/7/21

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F 684	Continued From page 45 Findings included: Resident #40 was admitted to the facility on 10/03/2019 with diagnoses including brain disorder and convulsions. A review of the most recent quarterly minimum data set assessment (MDS) for Resident #40 dated 03/02/2021 indicated she was rarely or never understood. It further indicated Resident #40 required the total assistance of one person for bed mobility, extensive assistance of one person for transfers, and required staff assistance to stabilize during transfers from bed to chair. Resident #40 had no falls since her prior assessment. A review of the current care plan for Resident #40 indicated a focus area initiated 10/03/2019 last reviewed on 03/02/2021 of at-risk for injury related to falls. The goal was Resident #40's risk for falls would be minimized with fall interventions in place through the next review. Interventions included to assess the need for siderails and floor mat. A review of a nursing progress note dated 08/28/2020 at 08:20 AM written by Nurse #8 indicated at the start of her 11PM-7AM shift, she observed Resident #40 on her knees at her bedside with her midsection between the half side rails of her bed. The note further indicated Nurse #8 went to get 3PM-11PM Nurse #4 who was still present on the unit to tell her Resident #40 was on the floor. The note went on to say when Nurse #8 and Nurse #4 got back to Resident #40's room, Resident #40 had already been put back in bed by the nursing assistant (NA). On 04/08/2021 at 4:22 PM an interview with	F 684	medical professional before staff move a resident after the resident experiences a fall 3. Facility staff were inserviced regarding that a resident who has experienced a fall needs to be assessed by a licensed medical professional before that resident is moved. This in-service will be completed by 5-7-2021. 4. An audit will be performed by the DON or their designee to ensure that any resident who experiences a fall is assessed by a licensed medical professional before that resident is moved. This audit will be performed weekly x 4 weeks and then monthly x 3 months. 5. The results of this audit will be taken to the facility monthly QA&A meeting to ensure that any resident who experiences a fall is assessed by a licensed medical professional before that resident is moved.	

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Nurse #4 indicated she was sitting at the nurse's station when Nurse #8 notified her Resident #40 was on her knees on the floor next to her bed. She stated she immediately went to Resident #40's room to assess her for injury and didn't find any. Nurse #4 further indicated when she got to Resident #40's room to do the initial assessment, Resident #40 was already back in bed. She stated the incident was a long time ago and she could not say which NA put Resident #40 back in bed before she was assessed for injury. Nurse #4 went on to say NA's should keep the resident safe after a fall and not move them until they were assessed by a licensed medical professional. Nurse #4 stated she had not notified anyone Resident #40 had been moved before being assessed for injury.

On 04/09/2021 at 10:52 AM an interview with Nurse #8 indicated when she observed Resident #40 on her knees at her bedside, she notified an NA and went to get Nurse #4. Nurse #8 stated when she and Nurse #4 returned to Resident #40's room, Resident #40 was already back in her bed. Nurse #8 stated she had not assessed Resident #40 for injury prior to Resident #40 being returned to her bed. She further indicated she did not recall which NA she notified or who put Resident #40 back in bed before she was assessed for injury.

On 04/09/2021 at 8:56 AM an interview with the director of nursing (DON) indicated she was not employed at the facility in August 2020. She stated the previous DON had taken all the staff assignment sheets with her when she left, she could not determine which NA had been assigned to Resident #40 at the time of her fall and did not have any other information regarding the incident.

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The DON went on to say NA's should not move a resident after a fall until they were assessed for injury by a licensed medical professional. She stated this information was included in new orientation and well as follow-up in-service training on falls for NA's.

A review of a list of NA staff provided by the DON indicated NA #8, NA #9 and NA #10 were present in the facility on 08/27/2020 11PM-7AM.

NA #8 was an agency staff member no longer employed by the facility and was not available for interview.

On 04/09/2021 at 2:41 PM a telephone interview with NA #9 indicated she did not recall assisting Resident #40 back to bed after a fall before she was assessed for injury by a licensed medical professional. She stated she was trained not to move a resident after a fall until a nurse checked them for injuries.

On 04/09/2021 at 2:46 PM a telephone interview with NA #10 indicated she did not recall assisting Resident #40 back to bed after a fall before she was assessed for injury by a licensed medical professional. She stated she was trained not to move a resident after a fall until a nurse checked them for injuries.

On 04/09/2021 at 12:41 PM an interview with Physician #1 indicated Resident #40 should not have been moved after her fall until she was assessed for injury by a licensed medical professional.

On 04/12/2021 at 2:59 PM a telephone interview with the administrator indicated Resident #40

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F 684	Continued From page 48 should not have been moved after her fall until she was assessed for injury by a licensed medical professional.	F 684		
F 686 SS=J	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and physician interview, the facility failed to assess and identify for pressure injury areas for 1 of 4 residents reviewed for pressure ulcers (Resident #38). Upon admission to the hospital, the hospital identified the presence of four pressure areas. Three areas were deep tissue wounds and one was unstageable. Following readmission to the nursing home, treatment records were not consistently documented as completed. Immediate jeopardy began on 6/25/20 when the facility failed to assess and identify pressure injury areas for Resident #38. Resident #38 was sent to the hospital and 4 pressure injury areas	F 686	1. A. An updated skin check was performed on resident #38 on 4-9-2021. B. The 2 employees who would have worked on 7-5-20 and 7-31-20 who would have been responsible for documentation on resident #38's TAR are no longer working for the company. 2. A. Skin checks were performed on all residents at the facility on 4-9-2021. The skin check schedules within the EMR were checked to ensure that weekly skin checks were scheduled for all residents.	5/13/21

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were identified as present on admission. The immediate jeopardy was removed on 4/12/21 when the facility provided and implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity level D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure that the education and the monitoring systems put in place to remove the immediate jeopardy are effective and to correct current deficient practice as identified in 1.b.

Findings included:

1.a. Resident #38 was admitted to the facility on 9/22/15. She was discharged to the hospital on 6/25/20 and returned to the facility on 6/30/20. She had diagnoses which included dementia and right above the knee amputation.

The Minimum Data Set dated 6/14/20 indicated Resident #38 was moderately cognitively impaired and was coded as total dependence for most activities of daily living except was independent with locomotion on the unit. She was coded as always incontinent for bowel and bladder. She was also coded as at risk for development of pressure ulcers or injuries.

Resident #38's care plan revised on 6/25/20 revealed a focus for the potential for pressure ulcer development related to a history of ulcers, immobility, bowel and bladder incontinence, fragile skin, weight loss and decreased oral intake. Care plan interventions for this goal included to follow facility policies and protocols for the prevention and treatment of skin breakdown and education of the resident, family and

B. An initial audit will be completed to ensure that TAR's are filled out accurately for the residents in the facility.

3. A. The nursing staff employed by the facility were inserviced on the weekly skin assessments that are to be completed. The facility licensed nursing staff were also inserviced on the process of informing the treatment nurse regarding any new skin injuties to a resident. These inservices were completed by 4-12-2021.

B. The facility nurses were inserviced on ensuring that when treatments are performed that the TAR is filled out accurately. This in-service will be completed by 5-13-2021.

4. A. An audit will be performed by the DON or their designee to ensure that the weekly skin assessments are being performed on the residents of the facility. This audit will take place weekly x 4 weeks and then monthly x 3 months.

B. An audit will be performed by the DON or their designee to ensure that the TAR's are being filled out when treatments are performed on the residents of the facility. This audit will take place weekly x 4 weeks and then monthly x 3 months.

5. The results of this audit will be taken to the facility monthly QA&A meeting to ensure that the weekly skins assessments are being completed on the residents of the facility and that the TAR's are being filled out when treatments are performed.

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caregivers as to the causes of skin breakdown including transfer and positioning requirements, good nutrition and frequent repositioning.

Facility weekly skin assessments revealed a skin assessment dated 5/30/20 which identified no skin injuries or wounds were identified. Nurse #11 had completed Resident #38's weekly skin assessment on 5/30/20 and he was interviewed on 4/09/21 at 12:48 PM. He stated he completed skin assessments whenever the 'system popped up' for him to complete them and he did not remember this particular assessment.

Resident #38's facility weekly skin assessments revealed no skin assessments from 5/30/20 through 7/18/20 were documented under the skin assessment tab in the electronic medical record.

Physician's orders revealed no right leg, heel, or foot wound care orders for June 2020.

The June 2020 Treatment Administration Record (TAR) revealed no treatments completed for Resident #38's right leg, heel, or foot.

Review of the hospital history and physical dated 6/26/20 read that Resident #38 presented to the hospital on the evening of 6/25/20 with lethargy, altered mental status and abnormal lab.

Resident #38's hospital records dated 6/26/20 and 6/30/20 revealed she had 4 pressure injury areas identified as present on admission. These four pressure injury areas were: (1) a deep tissue injury (DTI) to the right lateral, distal foot; (2) a DTI to the right distal, lateral, proximal foot; (3) a DTI to the right lateral ankle; (4) and an unstageable area to the right heel.

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Resident #38's facility nursing admission/readmission assessment dated 6/30/20 read that she had an unstageable right heel pressure injury; a pressure injury DTI to the right lateral foot; a pressure injury unstageable to the right lateral foot; and another pressure injury DTI to the right lateral foot.

An interview with the Nursing Assistant (NA) #3 on 4/09/21 at 12:29 PM revealed she provided care for Resident #38 in June 2020. She stated she gave her daily baths and if she had seen anything on her right leg, foot or heel, she would have reported it to the nurse. She stated the resident wore socks and padded boots which she removed during bathing.

An interview with Nurse #2 on 4/09/21 at 12:41 PM revealed the hall nurses were responsible for completion of Resident #38's weekly skin assessment. She stated the NAs were also responsible for notifying the nurse of any wound concerns noted during resident care. Nurse #2 stated the hall nurse was responsible for assessment of any skin or wound areas and initiating a referral to the Wound Care Nurse. She did not remember if she had performed any skin assessments on Resident #38 during June 2020.

An interview with Wound Care Nurse #1 on 4/09/21 at 8:16 AM revealed she was responsible for ensuring wound care was provided for Resident #38. She stated the hall nurses were responsible for completing the weekly skin assessments and referrals to her for any observed wounds. She stated she had not been notified in June of any pressure areas for Resident #38's right leg, foot, or ankle prior to her

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return from the hospital on June 30. She stated she became aware of Resident #38's right leg pressure areas after she returned from the hospital on June 30. Her assessment and treatment orders for Resident #38 on 6/30/20 included: an unstageable pressure injury to the right heel, a DTI to the right lateral foot, an unstageable pressure injury to the right lateral foot, and a DTI to the right lateral foot.

An interview with Resident #38's current physician on 4/09/21 at 10:57 AM revealed she was not the resident's physician in June 2020. She stated the resident had multiple comorbidities, poor nutrition, and very fragile skin.

An interview with the Director of Nursing (DON) on 4/09/21 at 9:39 AM revealed she had become aware in December 2020 that weekly skin assessments had not been completed and had been working to correct this. She also revealed she was not employed at the facility in June and had no knowledge of whether Resident #38 had pressure wounds or not.

An interview with the Administrator on 04/09/21 at 3:30 PM revealed he was unaware of any concerns related to wound care for Resident #38.

The Administrator was notified of Immediate Jeopardy on 4/09/21 at 3:30 PM. On 4/10/21 the facility provided the following credible allegation of Immediate Jeopardy removal.

East Carolina Rehabilitation and Wellness

Credible Allegation for F686 for removal of Immediate Jeopardy completed on 4/10/21

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I. Resident #38 is the only identified resident who has suffered or is likely to suffer a serious adverse outcome as a result of noncompliance

II. Resident #38 had a full body skin assessment performed to ensure that any pressure ulcers are properly identified. No new skin injuries were identified at this time. This assessment was completed on 4-9-2021. This assessment was completed by the Treatment Nurse.

B. Every other resident in the facility had a full body skin assessment performed by a nurse. The skin assessments were performed to identify any new skin injuries. Any new skin injuries will be reported to the treatment nurse and attending physician as identified. These assessments were completed on 4-9-2021. The DON or ADON will review all performed skin assessment to ensure that any new areas are properly reported to the treatment nurse and attending physician.

C. The facility licensed nursing staff were inserviced on the weekly skin assessments that are to be completed. The facility licensed nursing staff were also inserviced on the process of informing the treatment nurse regarding any new skin injuries to a resident. The inservices were performed by the DON and ADON and will be completed on 4-12-2021.

D. Upon admission to the facility, the newly admitted resident will have a skin assessment performed by a licensed nurse. After the initial skin assessment is performed on admission a weekly skin assessment will be performed by a licensed nurse on a weekly basis.

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E. The aides who are employed by the facility will be inserviced on the procedure of reporting any noticed skin issues to their nurse and how the nurse will handle that information. The licensed nurses will be inserviced on what to do when their aides report new skin conditions to them including a visual assessment, documentation and notifying attending physician, treatment nurse and nursing management. These inservices will be performed by the DON or ADON and will be completed by 4-12-2021.

F. The facility treatment nurse will be doing the admission skin assessment, in the event that the treatment nurse is not working then the cart nurse will perform the skin assessment. The treatment nurse has already been notified regarding this and was reminded on 4-9-2021.

G. The med cart nurses will be responsible for completing the weekly skin assessment. The nurses were inserviced by the DON/ADON on this and this inservice will be completed by 4-12-2021.

H. Staff are going to be inserviced during a mandatory inservice that they will attend at the facility. If any are unable to attend, then the DON or ADON will call those staff members and perform the inservice via phone.

I. On March 31st an inservice was given to the licensed nurses regarding how to assess, stage and describe pressure ulcers. The DON and/or ADON will also make rounds with the treatment nurse to ensure pressure ulcers are assessed and staged appropriately.

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J. The DON and/or ADON will be monitoring the skin assessment to ensure that they are completed in a timely manner. They will review the skin assessments 2 times a week to ensure completion.

We will have the above completed by 4-12-2021

The credible allegation was verified on 4/13/21 as evidenced by record review and staff interviews.

Interviews were conducted with a sample of staff members to verify education was conducted for all employees regarding completion of weekly skin assessments and the procedure of reporting any noticed skin issues to their nurse and how the nurse will handle that information.

Documentation of in-service records were reviewed.

A sample of weekly resident skin assessments was conducted.

All of the evidence indicated the facility had removed the Immediate Jeopardy by 4/12/21.

1.b. The July 2020 TAR revealed treatments as follows:
1.Bactroban ointment (antibacterial ointment) started on July 1. To be applied to the right heel every Monday, Wednesday, and Friday. This was initialed as completed as ordered except was not signed as completed for July 31.
2. Cleanse right lateral foot DTI and apply skin preparation and cover with a dressing daily. This was initialed as completed July 1 through July 31, except July 5 was not initialed as completed.

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F 686	Continued From page 56 3. Apply Santyl ointment (a debriding agent) to the right ankle daily. This was initialed as completed July 1 through July 31, except July 5 was not initialed as completed. 4. Apply Santyl ointment to the right lateral foot in 2 areas daily. This was initialed as completed July 1 through July 31, except July 5 and July 31 were not initialed as completed. An interview with Nurse #11 on 4/09/21 at 12:48 PM revealed he did treatments if it 'popped up in the system' for him to do them and he did not remember if he had ever completed a treatment on Resident #38. He also revealed if he had completed a treatment, he had signed as completed on the TAR. An interview with Wound Care Nurse #1 on 4/09/21 at 8:16 AM revealed she did not know if the unsigned were completed or not. She stated if she was not at the facility, it was the responsibility of the hall nurse to complete the treatments. She also stated if she completed a treatment, she signed it on the TAR.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and	F 689	1. The side rails on resident #49 bed	5/7/21

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F 689	Continued From page 57 record review the facility failed to repair a loose siderail which resulted in a fall with injuries for 1 of 4 residents (Resident #49) reviewed for accidents and hazards. Findings included: Resident #49 was admitted to the facility on 10/19/2016 with the diagnoses of seizure disorder, right above the knee amputation, and left below the knee amputation. A care plan initiated on 5/1/2020 focused on risk for falls related to dependence on staff for transfers, mobility, and bilateral lower extremity amputations. The interventions included assess the need for fall interventions and apply as directed. The care plan indicated Resident #49 required one staff member assistance for bed mobility, toileting, turning, and repositioning. A quarterly Minimum Data Set (MDS) dated 6/8/2020 revealed Resident #49 was unable to be assessed for a cognitive status and could not make his needs known. The MDS indicated Resident #49 required total assistance with bed mobility, transfers, was non-ambulatory, and had an impairment of the both upper and lower extremities. The MDS indicated Resident #49 required one-person assistance for all activities of daily living except two people and a mechanical lift for transfers. A nursing note dated 7/16/2020 at 7:46 am revealed Nurse # 8 heard Nurse Aide #5 calling for help in Resident #49's room. The note revealed upon entering the room Nurse #8 observed Resident #49 with the right side of his face on the floor and part of his left leg on the bed. Nurse #8 assisted NA #5 to lower Resident	F 689	were inspected to ensure that they were not loose and in good working order 2. An initial audit was performed on the bed rails within the facility to ensure that (1) bed rails were not loose and (2) bed rails were in proper repair. 3. The facility staff were inserviced on the procedure of letting the maintenance department know of any issue dealing with a loose bed rail or a bed rail that needs to be replaced or repaired. The in-service will be completed by 5-7-2021. 4. An audit will be performed by the DON or their designee to ensure that all bed rails in the facility are in good pair and not in the need of adjustment, repair or replacement. This audit will take place weekly x 4 weeks and then monthly x 3 months. 5. The results of this audit will be taken to the facility monthly QA&A meeting to ensure that the all bed rails in the facility are in good repair and not in the need of adjustment, repair or replacement.	

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#49 to the floor and on his back. The note indicated it took three staff members to assist Resident #49 back on the bed. The note revealed the physician and responsible party was notified.

A witnessed fall report dated 7/16/2020 indicated Resident #49 had an abrasion on the top of the scalp from the fall. The area was cleansed with normal saline, covered with a Vaseline gauze, and tegaderm. The report revealed Resident #49's siderail was not working properly when the fall occurred. The report does not specify which siderail was not working properly.

An emergency room (ER) physician note dated 7/16/2020 revealed Resident #49 presented to the ER due to an accidental fall. The computerized tomography (a series of x-rays) showed superficial subcutaneous hematoma (bleeding under the skin outside of the blood vessel) in the high neck and occipital (lower back of the head). The physician skin assessment indicated Resident #49 had a 5 centimeter (cm) by 2 cm skin abrasion to the right upper side of the head with smaller abrasions to the right side of the face and scalp.

The physician progress noted dated 7/22/2020 revealed while receiving care Resident #49 was turned over and toppled out of bed. The note indicated during the assessment Resident #49 had an abrasion on the top of his head with a bandage in place.

An observation on 4/5/2021 at 9:40 am revealed Resident #49 resting in the bed with bilateral three-quarter siderails positioned up and locked in place on the bed.

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An observation 4/6/2021 at 10:00 am revealed Resident #49 in the bed with his eyes closed. Bilateral three-quarter length siderails were in the up position and locked in place on the bed.

During a telephone interview with Nurse Aide (NA) #5 on 4/7/2021 at 6:20 am she revealed she was in Resident #49's room performing incontinent care and turned him on his side towards the wall. She said the back siderail went down on its own accord and Resident #49 rolled off the bed. NA #5 said she called out for help and Nurse #8 came to Resident #49's room to assist her. She stated after Nurse #8 had completed the assessment for injuries Resident #49 was assisted back to bed.

An interview with Nurse #5 on 4/7/2021 at 9:35 am revealed she had told the previous Director of Nursing (DON) #2 about the loose siderail around two weeks before the fall. She said she did not check back to see it the siderail had been repaired. Nurse #8 said she heard a call for help down the hall and went down the hall to Resident #49's room to help. She revealed upon entering the room she observed Resident #49 with the right side of his head on the floor and the left leg on the bed. Nurse #8 stated she assisted NA #5 to lower Resident #49 to the floor and on his back. During the assessment Nurse #8 observed an abrasion to the right side of Resident #49's head. She stated she called the Physician and the responsible party about the fall and obtained an order to transfer the resident to the emergency room for evaluation.

During an interview with the Maintenance Director on 4/8/2021 at 1:00 pm he stated Resident #49's loose siderail was not reported to the

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F 689	Continued From page 60 maintenance department. The Director said he did not have a work request for Resident #49's loose siderail. He stated he did not recall a verbal request for a repair for the siderail. The interview with DON #2 on 4/8/2021 at 2:47 pm revealed she recalled someone telling her Resident #49's siderail was loose. DON #2 stated she did not recall if she reported it to be repaired, but she thought that she did. During an interview with the DON #1 on 4/8/2021 at 3:37 pm she stated, "Nurse #8 had the same right as everyone else to inform the maintenance department of the loose siderail and to fill out a work order." The DON said after filling out a work order Nurse #8 could have told DON #2 then the siderails would have been repaired. An interview with the Maintenance assistant on 4/8/2021 at 4:00 pm revealed he was told about Resident #49's loose siderail on 7/16/2020 when he reported to work around 8:00 am. He stated the siderail was repaired immediately. During an interview with the Administrator on 4/9/2021 at 9:30 am he stated Resident #49's loose siderails should have been reported and repair in a timely manner. The Physician stated during an interview on 4/9/2021 at 10:30 am she recalled the staff informing her of Resident #49's fall out of the bed. She said she had assessed him on 7/22/2021. The Physician stated there was no changes in Resident #49's medical condition due to the fall.	F 689		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5)	F 693		5/7/21

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F 693	Continued From page 61 §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to separate the tube feeding syringe components stored for use for 2 of 3 residents (Resident #49 and Resident #23) and failed to date the tube feeding syringe storage bag for 1 of 3 residents (Resident #49) reviewed for tube feeding. This practice has the potential for causing contamination. Findings included: 1. Resident #49 was admitted to the facility on 06/29/2019 with diagnoses including dementia and dysphagia (difficulty swallowing).	F 693	1. A. The tube feeding syringe components for resident #23 and #49 were separated in their storge bag. B. The tube feeding syringe storage bag for resident #49 was dated 2. An initial audit was performed to ensure that the tube feeding syringe components were being separated when placed in the storage bag and also that the storage bag for the tube feeding syringe was properly dated. 3. The nurses were inserviced on	

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F 693	Continued From page 62 A review of the quarterly minimum data set (MDS) assessment for Resident #49 dated 03/07/2021 indicated he was rarely if ever understood. It further indicated he required the total assistance of one person to eat and received more than 51% (percent) of his calories and more than 501cc (cubic centimeters) of his fluid intake daily through tube feeding. On 04/08/2021 at 1:43 PM an observation was made of the tube feeding equipment for Resident #49. The observation revealed a 60cc tube feeding syringe stored with the plunger inside the barrel in a clear plastic bag on his bedside table. The syringe had visible cloudy liquid in the tip. There was no date visible on the syringe or the bag. On 04/08/2021 at 1:53 PM an interview with Nurse #1 indicated she was the nurse assigned to Resident #49 that day. She stated Resident #49 had a 60cc syringe dated 04/08/2021 in his room that morning but she dropped it on the floor before using it, discarded it and had gotten a new one which she forgot to date. She went on to say she used this undated 60cc syringe to check for residual (connecting the syringe to the feeding tube and drawing back the plunger of the syringe to withdraw stomach contents) and then used the syringe to provide Resident #49 with his tube feeding and water flush. She stated she had also used it to administer Resident #49's medications that morning. Nurse #1 stated she received orientation on the facility policy for tube feeding administration but did not recall this including instructions to store the plunger and barrel of the syringe separately in the bag after use.	F 693	ensuring that when storing the tube feeding syringes that the syringe components were kept separated and that the tube feed syringe storage bag was properly dated. The in-service will be completed by 5-7-2021. 4. An audit will be performed by the DON or their designee to ensure that the tube feeding syringe components are being kept separated when placed in the storage bag and that the storage bags are being properly dated. This audit will take place weekly x 4 weeks and then monthly x 3 months. 5. The results of this audit will be taken to the facility monthly QA&A meeting to ensure that the tube feeding syringe components are being kept separated when being stored in the storage bag and that the storage bag is properly dated.	

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F 693	Continued From page 63	F 693		

On 04/08/2021 at 2:04 PM an interview with the director of nursing (DON) indicated the facility tube feeding policy included instructions for staff to change the tube feeding syringes every 24 hours. She stated staff were to store the syringe with the plunger removed from the barrel in a clear plastic bag that was dated. The DON further indicated this was so the syringe could dry out between uses and for infection control. She went on to say Nurse #1 had been provided with instruction on the facility tube feeding policy in orientation and should be following the facility policy on dating the tube feeding equipment and storage of the syringe after use.

2. Resident #23 was admitted to the facility on 06/15/2020 with diagnoses including cerebral infarction (damage to brain tissue due to lack of oxygen).

A review of the quarterly minimum data set assessment (MDS) for Resident #23 dated 02/07/2021 indicated he was moderately impaired for daily decision making. It further indicated he required the total assistance of one person to eat and received more than 51% (percent) of his calories and more than 501cc (cubic centimeters) of his fluid intake daily through tube feeding.

On 04/08/2021 at 1:46 PM an observation was conducted of Nurse #1 administering a tube feeding to Resident #23. Nurse #1 was observed to complete the tube feeding by administering water, put the barrel and the plunger of the 60cc syringe back together, and place it in a clear plastic bag dated 04/08/2021. There was visible cloudy liquid in the tip of the syringe.

On 04/08/2021 at 1:53 PM an interview with

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F 693	Continued From page 64 Nurse #1 indicated she was the nurse assigned to Resident #23 that day and had used this 60cc syringe to check for residual (connecting the syringe to the feeding tube and drawing back the plunger of the syringe to withdraw stomach contents) prior providing Resident #23 with his tube feeding and water flush. She stated she also used it to administer Resident #23 his medication that morning. Nurse #1 stated she received orientation on the facility policy for tube feeding administration but did not recall this including instructions to store the plunger and barrel of the syringe separately in the bag. On 04/08/2021 at 2:04 PM an interview with the Director of Nursing (DON) indicated the facility tube feeding policy included instructions for staff to change the tube feeding syringes every 24 hours. She stated staff were to store the syringe with the plunger removed from the barrel in a plastic bag that was dated. The DON further indicated this was so the syringes could dry out between uses and for infection control. She went on to say Nurse #1 had been provided with instruction on the facility tube feeding policy in orientation and should be following the facility policy on dating the tube feeding equipment and storage of the syringe after use.	F 693		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.	F 700		5/7/21

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F 700	Continued From page 65 §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observations, Responsible Party and staff interviews, and record review the facility failed to provide alternatives to siderails, failed to complete siderail assessments, and failed to educate the responsible party on the risks and benefits of using siderails for 2 of 2 residents (Resident #49, Resident #40) reviewed for siderails. Findings included: 1. Resident #49 was admitted to the facility on 10/19/2016 with the diagnoses of seizure disorder, absence of the right above knee, and absence of left leg below the knee. A siderail screening form dated 3/3/2021 revealed Resident #49 was immobile. The form directed if the Resident was immobile, do not proceed any further. The screening form was incomplete. A quarterly Minimum Data Set (MDS) dated 3/7/2021 revealed Resident #49 was unable to be	F 700	1. A bed rail assessment was performed on resident #49 and #40. The responsible party for resident #49 and #40 were called to discuss possible alternatives to the side rails and to provide education on the risks vs. benefits of the side rails. 2. A bed rail assessment was completed on all residents with bed rails. The responsible party for those residents were called to discuss possible alternatives to the side rails and to provide the responsible party with education on the risks vs. benefits of those side rails. 3. The nurses were inserviced on bed rails including the need for the bed rail assessment and how often they are performed, calling the responsible party to discuss alternatives to side rails and to call the responsible party to provide them with education regarding the risks vs.	

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F 700	Continued From page 66 assessed for a cognitive status. The MDS indicated Resident #49 required total assistance with bed mobility, transfers, and was non ambulatory. The MDS revealed Resident #49 had an impairment of both upper and lower extremities. The MDS indicated Resident #49 siderails were not used as a restraint. A care plan with the latest review date of 3/11/2021 revealed no plan for the use of siderails. An observation on 4/5/2021 at 9:40 am revealed Resident #49 resting in the bed with bilateral three-quarter siderails positioned up on the bed. An observation 4/6/2021 at 10:00 am revealed Resident #49 in the bed with eyes closed. Bilateral three-quarter length siderails were in the up position on the bed. The interview with Nurse #7 on 4/6/2020 at 2:07 pm revealed the hall Nurses or MDS nurses did not participate in the siderail screening. Nurse #7 stated there were no attempts for alternative measures for the siderails. Nurse #7 said Nurse #10 was assigned to complete the siderails screening. An interview with Nurse Aide (NA) #3 on 4/7/2021 at 11:06 am revealed NA #3 was very familiar with Resident #49. NA #3 stated Resident #49 always had his siderails up on the bed. NA #3 said the siderails were up to keep the resident from falling off the bed when he was repositioned or received care. NA #3 stated Resident #49 required one-person assistance for activities of daily living and two-person assistance for transfers.	F 700	benefits of side rails. The in-service will be completed by 5-7-2021. 4. An audit will be performed by the DON or their designee to ensure (1) that bed rail assessments are completed on those residents with bed rails (2) that the responsible party was called to talk about possible alternatives to side rails and (3) that the responsible party was called and provided with education regarding the risks vs. benefits of using side rails. This audit will be performed weekly x 4 weeks and then monthly x 3 months. 5. The results of this audit will be taken to the facility monthly QA&A meeting to ensure that the bed rail assessments are being completed as scheduled, that responsible parties are being contacted regarding possible alternatives to the side rails and that the responsible parties are being educated regarding the risks vs. benefits of using side rails.	

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During a telephone interview with Nurse #10 on 4/8/2021 at 9:41 am he stated he did not complete an assessment for the use of siderails and did not try any alternatives for Resident #49. Nurse #10 said the siderails were already on Resident #49's bed when he assessed to make sure it was the appropriate siderails. Nurse #10 stated he does not make the decision for the use of siderails. Nurse #10 revealed he did not educate Resident #49's Responsible Party on the benefits and risks of siderails because he had not been told to provide the education.

A telephone interview with Resident #49's Responsible Party on 4/8/2021 at 3:00 pm revealed he was not informed of the need for siderails before the siderails were applied. The Responsible Party stated he did not have a problem with Resident #49 having the siderails up. The Responsible Party stated the facility did not educate him on the risks and benefits of using siderails.

The Director of Nursing (DON) on 4/8/2021 at 4:45 pm stated alternatives should have been tried for Resident #49 before applying siderails. The DON stated if Resident #49 did not have the siderails he would need 2 male NAs to assist with care for safety due to obesity and resistance to care. The DON said the siderail screening should have been completed to indicate the need for siderails. The DON revealed Nurse #10 should have educated Resident #49's Responsible Party on the benefits and risks of using siderails. The Don said Resident #49 had the siderail for safety and positioning. The DON was unable to say how the decision was made initially to have Resident #49 siderails up because she did not work at the facility at that time.

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Resident #49's record review revealed no further documentation concerning siderails.
2. Resident #40 was admitted to the facility on 10/03/2019 with diagnoses including brain disorder and convulsions.

A review of the most recent quarterly minimum data set assessment (MDS) for Resident #40 dated 03/02/2021 indicated she was rarely or never understood. It further indicated Resident #40 required the total assistance of one person for bed mobility, extensive assistance of one person for transfers, and staff assistance to stabilize during transfers from bed to chair. Resident #40 had no falls since her prior assessment and side rails were not used as a restraint.

A review of the current care plan for Resident #40 indicated a focus area initiated 10/03/2019 last reviewed on 03/02/2021 of at-risk for injury related to falls. The goal was Resident #40's risk for falls would be minimized with fall interventions in place through the next review. Interventions included to assess the need for side rails and floor mat.

On 04/05/2021 at 10:57 AM an observation was made of Resident #40 in bed. Bilateral three-quarter length side rails were in place on the bed and in the upright position.

On 04/06/2021 at 8:27 AM an observation was made of Resident #40 in bed. Bilateral three-quarter length side rails were in place on the bed and in the upright position.

On 04/08/2021 at 9:29 AM a telephone interview

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with Resident #40's representative indicated she was aware Resident #40 had side rails. She stated Resident #40 had them in place since her admission to the facility as a fall precaution because she could wiggle her legs off the bed. The representative stated she did not recall any recent conversations with the facility but when Resident #40 was first admitted she told staff she wanted Resident #40 to have side rails and she wanted them to remain in place. She stated she didn't recall anyone telling her about any alternatives to side rails for fall prevention or discussing any risks versus benefits with her.

On 04/06/2021 at 2:07 PM an interview with Nurse #7 indicated Nurse #10 was responsible for completing the side rail assessments for residents in the facility.

A review of the side rail screening document for Resident #40 dated 02/27/2021 completed by Nurse #10 indicated the use of side rails. It further indicated side rails served as an enabler to facilitate transfer, bed mobility and/or positioning. The side rail screening revealed Resident #40's representative had expressed a desire to have side rails raised while Resident #40 was in bed. No documentation was found on the side rail assessment or in Resident #40's medical record that any alternatives to side rail use were tried or any discussion of risks versus benefits of side rail usage occurred with Resident #40's representative.

On 04/08/2021 at 3:59 PM a telephone interview with Nurse #10 indicated he competed the side rail assessment for Resident #40 dated 02/27/2020. He stated he had also done previous side rail assessments for Resident #40 and was

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F 700	Continued From page 70 familiar with her since her admission to the facility. Nurse #10 stated on admission Resident #40's representative requested Resident #40 have side rails to prevent falls. He stated he never discussed any risks versus benefits of side rail use with Resident #40's representative and no alternatives to side rail use for Resident #40 had been attempted. On 04/09/2021 at 08:17 AM an interview with NA #10 indicated she was assigned to Resident #40 that day and was familiar with her care. She stated she assisted Resident #40 with transfers out of bed and positioning in bed and Resident #40 was not able to use her side rails to assist with transfers or with positioning. On 04/09/2021 at 8:56 AM an interview with the director of nursing (DON) indicated side rails were an intervention that needed to be critically evaluated. She stated this evaluation should include an attempt at alternatives to side rail use and a discussion of the risks versus the benefits of side rail use with the resident or the resident's representative.	F 700		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic	F 758		5/7/21

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F 758	Continued From page 71 Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff,	F 758	1. A stop date for the antipsychotic for	

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F 758	Continued From page 72 pharmacist, and physician interviews the facility failed to have a stop date for an as needed antipsychotic medication for 1 of 5 residents reviewed for unnecessary medications (Resident #45). Findings included: Resident #45 was admitted to the facility on 2/26/21. A review of Resident #45's minimum data set assessment dated 3/5/21 revealed he was assessed as cognitively intact. He was assessed to have hallucinations. His active diagnoses included hypertension, diabetes mellitus, Parkinson's disease, depression, and restlessness with agitation. He received an antipsychotic 7 of the previous 7 days. A review of Resident #45's care plan dated 3/18/21 revealed he was care planned for psychotropic medication use for quetiapine routine and as needed. The interventions included to monitor for medication effect, pharmacy review per policy, monitor for mental status changes, administer medication per orders, document adverse behaviors, and notify the physician as indicated. A review of Resident #45's orders revealed on 2/26/21 he was ordered quetiapine fumarate tablet 25 milligrams give 0.5 tablet by mouth every 12 hours as needed for agitation. There was no end date to the medication order. A review of a pharmacy consult recommendation dated 3/25/21 revealed the pharmacist documented that Resident #45 was prescribed	F 758	resident #45 was obtained. 2. An audit was performed to ensure that any resident who has an order for a PRN antipsychotic medication has a stop date of 14 days since order. 3. The nurses were inserviced on ensure that for any PRN antipsychotic medication that a stop date of 14 days needs to be entered into the system and that after the 14 days the physician would have to review the mediation, provide a new order and have another 14 day stop date if the medication is PRN. The in-service will be completed by 5-7-2021. 4. An audit will be performed by the DON or their designee to ensure that any PRN antipsychotic medication has a 14 day stop date. This audit will be performed weekly x 4 weeks and then monthly x 3 months. 5. The results of this audit will be taken to the facility monthly QA&A meeting to ensure that any PRN antipsychotic medication that is prescribed to a resident has a 14 day stop date.	

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quetiapine 12.5 milligrams every 12 hours as needed for agitation. The recommendation was to consider discontinuing the medication. If the medication could not be discontinued at that time, the current regulation required the prescriber directly examine the resident to determine if the antipsychotic is still needed, document the diagnosed specific condition being treated, the intended duration of therapy, and the rational for the extended time period prior to issuing the new order. As needed antipsychotic drugs must be limited to 14 days. The physician's response to the recommendation was that the resident had a history of psychiatric diagnosis of Post-Traumatic Stress Disorder and aggression per the family provision of history required intervention. This response was signed on 3/26/21.

A review of Resident #45's medication administration record for February 2021 through April 2021 and orders revealed there was no change made to the order for quetiapine. A review of Resident #45's medication administration record from February 2021 through April 2021 revealed he did not receive the as needed medication; however, it was available to be given during that time.

During an interview on 4/6/21 at 10:19 AM Nurse #2 stated Resident #45 had 12.5 milligrams of quetiapine ordered as needed. This order had been in place since 2/26/21, did not have a stop date, and he had not required any dosages. She further stated the medication was on her cart and available to the resident should he begin to show signs of agitation that required giving the as needed medication.

During observation on 4/6/21 at 10:20 AM

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Resident #45's ordered quetiapine fumarate tablet 25 milligrams give 0.5 tablet by mouth every 12 hours as needed for agitation was on the medication cart and available.

During an interview on 4/6/21 at 10:28 AM the Director of Nursing stated antipsychotics cannot be ordered for longer than 14 days for as needed. She further stated she did not know why the physician chose not to put a 14 day stop date on the antipsychotic however, in this facility it should have been limited to 14 days.

During an interview on 4/6/21 at 11:34 AM Pharmacist #1 stated the response by the physician was not acceptable under the Centers for Medicare & Medicaid Services requirements for antipsychotic as needed use. She further stated antipsychotic as needed orders such as the quetiapine order for Resident #45 were required to have an end date of no further than 14 days and the physician must reassess the resident at that time in order to renew the medication order. The pharmacist concluded she would call the physician to speak with the physician to get the order changed.

During an interview on 4/7/21 at 9:35 AM Physician #1 stated she was aware that antipsychotic medications were to have a 14 day stop date. She further stated the issue with the medication was not fully brought to her attention by the facility and she would correct the order as it should have a stop date of 14 days from the order.

During an interview on 4/8/21 at 4:30 PM Nurse #5 stated she did enter Resident #45's order for quetiapine 25 milligrams give 0.5 tablet by mouth

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F 758	Continued From page 75 every 12 hours as needed 2/26/21. She concluded she did not notify Physician #1 the order did not have an end date because she was not aware that it needed one.	F 758		
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. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and record review the facility failed to secure a resident's medication by leaving the medication unattended on the bedside table for 1	F 761	1. A. The nurse taking care of resident #1 was spoken to regarding not leaving medication for any resident unattended in the resident room.	5/7/21

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F 761	Continued From page 76 of 26 residents reviewed for medication administration (Resident #2) and failed to lock an unattended medication cart (300 hall) for 1 of 3 medication carts reviewed for medication storage. Findings included: 1.Resident #2 was admitted to the facility on 10/29/2019. A Quarterly Minimum Data Set (MDS) dated 3/28/2021 indicated Resident #2 was moderately cognitively impaired. A care plan reviewed on 3/28/2021 focused on impaired cognitive function related to dementia or impaired thought process. The interventions included administer medications as ordered. There was no care plan for self-medication administration. An observation on 4/5/2021 at 9:55 am revealed Resident #2's morning medications included Minipress, Norvasc, Cozaar (blood pressure), omega 3 (high cholesterol) and guaifenesin (cough and congestion) was left in a medication cup on the bedside table. A cup of water was on the table beside the medications. The interview with Resident #2 on 4/5/2021 at 9:57 revealed Resident #2 was unaware the medications had been left on the bedside table. Resident #2 stated Nurse #11 must have brought the medication in the room while she was in the bathroom. An interview with Nurse #11 on 4/5/2021 at 10:00 am revealed Resident #2's medications had been carried in the room and left on the bedside table.	F 761	B. The 300 hall nurse was spoken to about making sure that their medication cart was fully locked when they stepped away from that medication cart. 2. An initial random audit was performed to ensure that no medications were being left unattended in a resident room and that the medication carts were locked when a nurse had walked away from the cart. 3. The nurses were inserviced regarding not leaving any medication unattended in a residents room and to ensure that their mediation cart was locked when they stepped away from the cart. The in-service will be completed by 5-7-2021. 4. An audit will be performed by the DON or their designee to ensure that no medications are being left unattended in a residents room and that the medication carts are being locked when a nurse has walked away from the cart. This audit will be performed weekly x 4 weeks and then monthly x 3 months. 5. The results of this audit will be taken to the facility monthly QA&A meeting to ensure that medications are not being left unattended in a residents room and that medication carts are being locked when the nurse steps away from the cart.	

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Nurse #11 stated Resident #2 was in the bathroom when he entered the room. Nurse #11 indicated the intention of going back to administer Resident #2's medications, so the Medication Administration Record (MAR) had been signed. Nurse #11 stated he knew the correct procedure for administering medications.

During an interview with the Director of Nursing (DON) on 4/6/2021 at 2:30 pm she stated when Nurse #11 learned Resident #2 was in the bathroom, Nurse #2 should have taken the medication back to the cart and locked the medications in the cart. The DON said Nurse #11 should have taken the medications back to Resident #2's room later and observe Resident #2 swallow the medications. The DON said there was no self-medication administration assessment because Resident #2 was unable to take her medications unassisted.

The Administrator stated on 4/9/2021 at 9:30 am Nurse #11 should not have left Resident #2's medications in the room. The Administrator said all medications should be in a secured place.
2. During observation on 4/6/21 at 8:28 AM the 300-hall medication cart was observed to be unlocked and unattended. The 300-hall nurse was in the room with a resident and her back was turned to the door and she could not see her medication cart. Three nurse aides were observed to be 15 feet away on the 300-hall. The medication cart was out of Nurse #1's view until 8:31 AM when she turned around and returned to the medication cart.

During an interview on 4/6/21 at 8:32 AM Nurse #1 stated when medication carts were out of nurses' view, the medication carts were supposed

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F 761	Continued From page 78 to be locked. She concluded because the 300-hall medication cart was out of her sight, it should have been locked. During an interview on 4/6/21 at 10:34 AM the Director of Nursing stated it was the facility policy that if the medication cart was to be left out of view of a nurse, the cart should be locked.	F 761		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 880		5/7/21

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F 880	Continued From page 79 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, 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	F 880	1. A. Going forward all staff are to wear	

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F 880	Continued From page 80 interviews the facility failed to ensure staff wore face masks or wore face masks correctly while interacting with residents and in resident care areas and failed to have staff offer hand hygiene to residents during meal service. In addition, the facility failed to ensure completion of hand hygiene upon entrance screening to the facility and failed to ensure a staff member completed entrance screening to the facility prior to entrance of the facility for 6 of 29 staff observed. This failure occurred during the COVID pandemic. (Wound Nurse #1, Nurse Aide #1, Housekeeper #1, Receptionist, Nurse Aide #3, and Nurse Aide #11) Findings included: 1. During observation on 4/6/21 at 8:34 AM Wound Care Nurse #1 was observed to walk from the 400 hall to the 200 hall. The nurse was not wearing a mask. She walked past another staff member on the 400 hall at 8:35 AM approximately 4 feet from the other staff who was wearing a mask. She then turned and began to walk down the 200 hall. Resident #52, who had pulled his mask down under his chin, was at the entrance to his room and she stopped to speak with him approximately 2 feet away from the resident. She then stepped past the resident into his room and exited his room at 8:36 AM. During an interview on 4/6/21 at 8:36 AM Wound Care Nurse #1 stated she was always supposed to wear a mask while in the facility. She concluded she forgot she was not wearing a mask and would go get one and put it on. During an interview on 4/7/21 at 2:40 PM the Director of Nursing stated Wound Care Nurse #1	F 880	masks when they are in the facility and wear masks the proper way. B. Going forward residents will have hand hygiene performed when their trays are being delivered to them C. Going forward the staff member performing entrance screening will ensure that the person being screen uses hand sanitizer upon completion of the entrance screen. D. Go forward all staff will be entrance screen when they leave facility property and return to the facility 2. All facility staff will receive an infection control inservice that is provided by the DON on the importance of infection control. The inservice will provide staff with the proper way to wear a mask, the importance of hand hygiene and the importance of being screened after leaving facility property. This directed plan of correction in-service was delivered by the DON (who is spice certified). This in-service included some staff handouts including the 3 W's from the NCDHHS website and also mask guidance from the CDC. The staff also watched a video which was Keep VOVID-19 Out! (https://youtu.be/7srwrF9MGdw). This in-service will be completed by 5-7-2021. 3. A root cause analysis of the infection control systems within the facility will be completed by 5-7-2021.	

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F 880	Continued From page 81 should not have been in the facility without a mask and should not have gone down a resident hallway and entered a resident room without a mask. 2. During observation on 4/5/21 at 12:04 PM Nurse Aide #1 was observed to enter Resident #50's room and provide the resident their meal tray. She did not offer Resident #50 hand hygiene. She set the tray down set up the meal. The nurse aide then used a fork to place a chicken wing in the resident's hand. She oriented Resident #50 to the location of her food on the tray and then left the room. The resident began to eat with her hands without performing hand hygiene. During observation on 4/5/21 at 12:07 PM Nurse Aide #1 was observed to enter Resident #31's room and provide the resident their meal tray. She set up the food tray for the resident and left the room. She did not offer hand hygiene to the resident. The resident began to eat without performing hand hygiene. During observation on 4/5/21 at 12:09 PM Nurse Aide #1 was observed to enter Resident #7's room and provide the resident their meal tray. She set up the food tray for the resident and left the room. She did not offer hand hygiene to the resident. The resident began to eat without performing hand hygiene. During observation on 4/5/21 12:13 PM Nurse Aide #1 was observed to enter Resident #39's room and provide the resident their meal tray. She set up the food tray for the resident and left the room. She did not offer hand hygiene to the resident. The resident began to eat without	F 880	4. The facility did partner with Delores Nobles, MT, MPH, CIC who is the Region 10 Coordinator for the Regional Prevention Support Team with NCDHHS. Ms. Nobles came to the facility on 4-29-2021 to talk with the Administrator, DON, ADON and Environmental Services Director. Ms. Nobles made a walk through the facility to make sure staff were following infection control policies. Ms. Nobles also spoke to random staff members about infection control issues such as donning/doffing PPE, talking about cleaning chemicals, PPE supplies, etc. Ms. Nobles stated she was impressed with our staff and how the facility was doing. 5. An audit will be performed by the DON or their designee to ensure that masks are being worn properly by all employees, that hand hygiene is being performed on residents as they receive their meal tray, that hand hygiene is begin performed after the completion of entrance screening and that employees are rescreened when they leave facility property and then return to the facility. 6. The results of this audit will be taken to the facility monthly QA&A meeting to ensure that masks are being worn properly by all employees, that hand hygiene is being performed on residents as they receive their meal tray, that hand hygiene is begin performed after the completion of entrance screening and that employees are rescreened when they leave facility property and then return to	

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F 880	Continued From page 82 performing hand hygiene. During an interview on 4/5/21 at 12:16 PM Nurse Aide #1 stated Resident #50 was blind which was the reason she would eat with her hands. She further stated she would put the food in Resident #50's hand to get her started and orient her to the location of her tray and then the resident would use her hands to eat. She further stated she did not have any education on offering hand hygiene to residents before meals because they usually did not offer hand hygiene prior to meals at this facility to her knowledge. During an interview on 4/7/21 at 2:40 PM the Director of Nursing stated staff should have offered hand hygiene prior to meals. She further stated staff had been educated and she would reeducate staff. 3. During observation on 4/5/21 at 10:18 AM Housekeeper #1 was observed with her face mask covering her mouth but under her nose allowing her nose to be exposed. At 10:18 AM she approached Resident #13 who was in the hall and began talking to the resident approximately 2 feet apart with her face mask still under her nose. At 10:33 AM Housekeeper #1 entered Resident #52's room and helped him with his phone. She leaned over the resident in order to assist him with her face mask still under her nose. At 11:11 AM Housekeeper #1 was observed with her mask still under her nose as she entered Resident #54's room, stood over the resident who was in her bed, and assisted the resident with her pillowcase. During an interview on 4/5/21 at 11:13 AM Housekeeper #1 stated the reason she wore her	F 880	the facility.	

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mask under her nose was because she could not breath well when it covered her nose. To her understanding, it was okay to wear her mask in that way.

During an interview on 4/7/21 at 2:40 PM the Director of Nursing stated masks were to cover the nose as well as the mouth and Housekeeper #1 should not have left the mask under her nose. She further stated the housekeeper had been in-serviced on this fact and should have known.

4. During observation on 4/6/21 at 8:06 AM Nurse Aide #1 was observed in Resident #1's room folding the resident's clothing. The nurse aide was approximately 7 feet from the resident. Her mask was observed to be pulled under her chin. Upon the surveyor passing the room, the nurse aide pulled her mask up over her mouth and nose. She did not perform hand hygiene following her adjustment of her mask and continued to place the resident's clothing.

During an interview on 4/6/21 at 8:07 AM Nurse Aide #1 stated staff were always to wear their masks to cover their mouth and nose. She further stated sometimes the mask would come off her face and she would have to readjust it. She concluded there was no reason she had her mask down under her chin while in a resident's room.

During an interview on 4/7/21 at 2:40 PM the Director of Nursing stated staff were to wear their mask to cover both their mouth and nose while in the facility and Nurse Aide #1 should not have been in a resident room with her mask down. She stated there had been multiple in-services about mask wearing and the nurse aide should have

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known.
5. During the screening process to enter the facility on 4/05/21 at 9:15 AM, 4/06/21 at 7:45 AM, and 4/06/21 at 8:00 AM, 5 of the 5 state surveyors were not required to perform hand hygiene. During the screening process to enter the facility on 4/07/21 at 7:45 AM, 1 of 1 state surveyors was not required to perform hand hygiene. During each of these entrance screenings, a hand sanitizer dispenser was observed at the facility entrance and a bottle of hand sanitizer was noted on the receptionist desk.

An interview with the Receptionist on 4/07/21 at 8:11 AM revealed she was responsible for screening visitors and staff. She stated she had not ensured the state surveyors performed hand hygiene because they made her nervous. She also stated she should ensure that everyone who entered the facility performed hand hygiene during the screening process.

An interview with the Administrator on 4/12/21 at 12:05 PM verified that the Receptionist should have ensured all visitors and staff performed hand hygiene during the entrance screening process and he did not know why she had not done so.

6. A continuous observation was made on 4/05/21 from 12:10 PM to 12:23 PM of the lunch trays being delivered to the residents' rooms. Nursing Assistant (NA) #3 was observed to enter Resident #219's room, deliver the resident's meal tray, open items on the tray, cut up the meat, and depart the resident's room. NA #3 did not offer or provide hand hygiene for the resident. NA #3 was observed to enter Resident #34's room, deliver

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the resident's meal tray, open items on the tray, and depart the resident's room. NA #3 did not offer or provide hand hygiene for the resident. NA #3 was observed to enter Resident #222's room, deliver the resident's meal tray, and depart the resident's room. NA #3 did not offer or provide hand hygiene for the resident. NA #3 was observed to enter Resident #217's room, deliver the resident's meal tray, open items on the tray, and depart the resident's room. NA #3 did not offer or provide hand hygiene for the resident. NA #3 was observed to enter Resident #53's room, deliver the resident's meal tray and depart the resident's room NA #3 did not offer or provide hand hygiene for the resident. NA did perform hand hygiene before entry and after exiting each resident's room during this observation.

An interview with NA #3 on 4/06/21 at 1:46 PM, she verified she had not offered or performed hand hygiene while delivering the lunch meal trays for the observed residents on 4/05/21. She stated she did not normally offer or provide hand hygiene to the residents before meals.

An interview with the Director of Nursing (DON) on 4/08/21 at 12:35 PM revealed all residents should be offered or provided hand hygiene before meals and she did not know why this had not been done.

An interview with the Administrator on 4/12/21 at 12:05 PM revealed all residents should be offered or provided hand hygiene before meals.

7. During an interview and observation on 4/9/21 at 11:05 AM Nurse Aide (NA) #11 was observed entering the side door of the facility and go into the dining room. She sat down in the dining room. During the interview NA #11 stated she

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F 880	Continued From page 86 forgot to complete the screening process upon entering the facility. She stated she would have remembered when she returned to her workstation because the nurse would have reminded her. NA #11 was observed going to the receptionist's office to complete the screening process. An interview was conducted with the Director of Nursing on 4/9/21 at 11:30 AM who stated NA #11 should have completed the screening process prior to entering the dining room. She stated staff have been in-serviced to complete the COVID-19 screening process upon entry into the facility.	F 880		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza	F 883		5/7/21

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F 883	Continued From page 87 immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide education regarding the benefits and potential side effects of the influenza and pneumococcal immunizations with documentation in the medical record for 4 of 5 sampled residents (Residents #2, #33, #39, and	F 883	1. A. Going forward the facility will provide education regarding the benefits and potential side effects of the influenza and pneumococcal immunizations with the responsible party and also ensure that this information is documented in the	

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F 883	Continued From page 88 #59) and failed to obtain consent or refusal of the pneumococcal immunization (Resident #59) for 1 of 5 sampled residents reviewed for immunizations. Findings included: 1. The facility's policy for immunization with no date was reviewed. The policy read in part that prior to the flu or pneumonia vaccine being given, the Resident and/or their Responsible Party must be educated regarding the benefits, risk and side effects of the immunization. It further read that it would be documented in the medical record that the Resident and/or Responsible Party would be educated regarding the benefits, risks, and potential side effects of the immunization. a. Resident #2 was admitted to the facility on 10/24/19 and most recent reentry to the facility was on 3/03/20. She had diagnoses which included diabetes mellitus. The most recent Minimum Data Set dated 3/28/21 indicated Resident #2 was moderately cognitively impaired. Resident #2's immunization records were reviewed. The records revealed she had received the influenza immunization on 10/10/20. The records did not indicate that education was provided to Resident #2 or her Responsible Party (RP) regarding the benefits and the potential side effects of the influenza immunization. Resident #2's immunization records also revealed she had received the pneumococcal immunization on 11/28/20. The records did not indicate that education was provided to Resident	F 883	EMR. B. Going forward the facility will ensure to obtain consent or refusal of pneumococcal immunizations with documentation in the EMR 2. The nurses were inserviced on (1) making sure to provide education regarding the benefits and potential side effects of the influenza and pneumococcal immunizations with the responsible party and to ensure that this information is documented in the EMR and (2) making sure to obtain consent or refusal for pneumococcal immunizations and to ensure that this information is documented in the EMR. This in-service will be completed by 5-7-2021. 3. An audit will be performed to ensure that the responsible party has been educated on the benefits and potential side effects of the influenza and pneumococcal immunizations and that this information is documented in the EMR and also that consent/refusal is obtained for pneumococcal immunizations and that this is documented in the EMR. This audit will be performed weekly x 4 weeks and then monthly x 3 months. 4. The results of this audit will be taken to the facility monthly QA&A meeting to ensure that the responsible party has been educated on the benefits and potential side effects of the influenza and pneumococcal immunizations and that	

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#2 or her RP regarding the benefits and the potential side effects of the pneumococcal immunization.

An interview with the Director of Nursing (DON) on 4/08/21 at 12:35 PM revealed she was unaware that Resident #2 had no education documentation for the influenza or pneumococcal immunizations. She stated the immunization education should have been documented in the resident's medical record.

An interview with the Administrator on 4/08/21 at 10:50 AM revealed he was unaware that Resident #2 had no education documented for her immunizations.

b. Resident #33 was admitted to the facility on 9/24/14 with diagnoses which included diabetes mellitus.

The most recent Minimum Data Set dated 2/14/21 indicated Resident #33 was cognitively intact.

Resident #33's immunization records were reviewed. The records revealed he had received the influenza immunization on 10/10/20. The records did not indicate that education was provided to Resident #33 or his Responsible Party (RP) regarding the benefits and the potential side effects of the influenza immunization.

Resident #33's immunization records also revealed he had received the pneumococcal immunization on 11/28/20. The records did not indicate that education was provided to Resident #33 or his RP regarding the benefits and the

this information is documented in the EMR and also that consent/refusal is obtained for pneumococcal immunizations and that this is documented in the EMR.

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potential side effects of the pneumococcal immunization.

An interview with the Director of Nursing (DON) on 4/08/21 at 12:35 PM revealed she was unaware that Resident #33 had no education documentation for the influenza or pneumococcal immunizations. She stated the immunization education should have been documented in the resident's medical record.

An interview with the Administrator on 4/08/21 at 10:50 AM revealed he was unaware that Resident #33 had no education documented for her immunizations.

c. Resident #38 was admitted to the facility on 9/22/15 and most recent reentry to the facility was on 12/21/20. She had diagnoses which included dementia and right above the knee amputation.

The most recent Minimum Data Set dated 2/20/21 indicated Resident #38 was moderately cognitively impaired.

Resident #38's immunization records were reviewed. The records revealed she had received the influenza immunization on 10/01/20. The records did not indicate that education was provided to Resident #38 or her Responsible Party (RP) regarding the benefits and the potential side effects of the influenza immunization.

Resident #38's immunization records also revealed she had received the pneumococcal immunization on 11/28/20. The records did not indicate that education was provided to Resident

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#38 or her RP regarding the benefits and the potential side effects of the pneumococcal immunization.

An interview with the Director of Nursing (DON) on 4/08/21 at 12:35 PM revealed she was unaware that Resident #38 had no education documentation for the influenza or pneumococcal immunizations. She stated the immunization education should have been documented in the resident's medical record.

An interview with the Administrator on 4/08/21 at 10:50 AM revealed he was unaware that Resident #38 had no education documented for her immunizations.

2. The facility's policy for immunization with no date was reviewed. The policy read in part that prior to the flu or pneumonia vaccine being given, the Resident and/or their Responsible Party must be educated regarding the benefits, risk and side effects of the immunization. It further read that it would be documented in the medical record that the Resident and/or Responsible Party would be educated regarding the benefits, risks, and potential side effects of the immunization. The policy also read in part that a consent form will be signed prior to the flu or pneumonia vaccine being given.

Resident #59 was admitted to the facility on 9/11/15 and most recent reentry to the facility was on 2/25/21 with diagnoses which included diabetes mellitus.

The most recent Minimum Data Set dated 3/14/21 indicated Resident #59 was severely cognitively impaired.

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Resident #59's immunization records were reviewed. The records revealed she had received the influenza immunization on 9/26/20. The records did not indicate that education was provided to Resident #59 or her Responsible Party (RP) regarding the benefits and the potential side effects of the influenza immunization.

Resident #59's immunization records also revealed her pneumococcal immunization had not been offered or given. The records did not indicate that consent, refusal, or education was provided to Resident #59 or her RP regarding the benefits and the potential side effects of the pneumococcal immunization.

An interview with the Director of Nursing (DON) on 4/08/21 at 12:35 PM revealed she was unaware that Resident #59 had no education documentation for the influenza immunization or whether she been offered, refused, or received the pneumococcal immunization. She stated the immunization education should have been documented in the resident's medical record. The DON also stated that Resident #59 should have been offered or given the pneumococcal immunization and documentation completed.

An interview with the Administrator on 4/08/21 at 10:50 AM revealed he was unaware that Resident #59 had no education documented for her influenza immunization or a consent or refusal documented for her pneumococcal immunization.