STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345537	A. BUILDING _____ B. WING _____	C 04/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-WILMINGTON, INC	2305 SILVER STREAM LANE WILMINGTON, NC 28401

(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 annual recertification and a complaint investigation was completed at this facility on 04/15/21. The Emergency Preparedness survey was conducted at this time and was found to be in compliance with 42 CFR 483.73.	E 000		
F 000	INITIAL COMMENTS A recertification and a complaint investigatoin survey was conducted from 04/05/21 through 04/15/21. Event ID# N2BZ11. Four of 4 complaint allegations was unsubstantiated.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff and resident interviews, the facility failed to follow the physician orders and inaccurately documented the physician ordered tasks as completed for 2 of 2 residents (Resident #22 and #43) observed. 1) The facility failed to follow the physician orders to apply compression stockings and pressure relief boots for Resident #22 and documented the tasks were completed in the electronic medical record; and 2) the facility failed to follow the physician orders to apply a resting left hand splint for Resident #43 and documented	F 684	Filing this plan of correction does not constitute admission that the deficiencies alleged did in fact exist. The plan of correction is filed in evidence of the facilities desire to comply with the requirements and continue to provide a high quality of care. Failure to appropriately apply splints, compression stockings, and pressure relief boots led to the deficiency.	5/10/21

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

Electronically Signed | 05/07/2021

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F 684	Continued From page 1 the tasks were completed in the electronic medical records. Findings included: 1. Resident #22 was admitted to the facility on 11/02/18. Diagnoses included, in part, paraplegia due to spinal injury and bilateral ankle contractures. The Minimum Data Set (MDS) quarterly assessment dated 01/25/21 revealed the resident was cognitively intact and demonstrated no behaviors of refusal of care. Resident #22 had impairments to bilateral lower extremities. A review of the revised care plan dated 01/27/21 revealed an initial care plan dated 03/08/19 for paraplegia/bilateral ankle contractures related to spinal injury with an intervention to include, in part, elevate heels and use protectors; and a care plan for at risk for pressure ulcer due to impaired sensory and paraplegia with impaired mobility. Interventions included, in part, elevate heels and use heel protectors, and skin assessments every shift with close attention to the heels. Physician orders revealed an order was written 08/08/19 for knee high compression stockings to bilateral legs to apply in the morning and remove in the evening, and an order was written on 04/30/20 to encourage pressure relief boots when in bed each shift. An observation of Resident #22 on 04/07/21 at 10:20 AM revealed the resident was lying in bed with lower extremities lying flat on the mattress with no compression stockings applied to bilateral extremities or pressure relief boots in place.	F 684	Residents Affected Corrective action has been accomplished for the alleged deficient practice in regards to residents #22 and #43. The physician's orders, care plan and resident profile for both residents was reviewed by the Minimum Data Set (MDS) Coordinator on 5/3/2021 to ensure both accurately reflect the residents current need for compression stockings, pressure relief boots and/or splints as appropriate. All equipment was deemed appropriate and applied to the residents per physician's order. This was completed by the Unit Coordinators by 5/6/2021. There were no adverse effects from equipment not being applied appropriately. Others with the potential to be affected All other residents requiring this equipment have the potential to be affected. The Director of Nursing (DON) and/or designee reviewed all other residents with physicians orders for compression stockings, pressure relief boots and splints to ensure that these items still accurately reflected the residents' current needs and that they were all in place as ordered. This was completed on 5/4/2021 and no other residents were affected by the alleged deficient practice. Systemic Changes The DON and/or designee will educate all licensed nursing staff regarding accurate	

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F 684	Continued From page 2 Resident #22 did not have any skin breakdown to the bilateral heels but had mild edema to the bilateral legs and feet. An observation of Resident #22 on 04/07/21 at 2:18 PM revealed the resident was lying in bed with lower extremities lying flat on the mattress with no compression stockings applied to bilateral extremities or pressure relief boots in place. Resident #22 did not have any skin breakdown to the bilateral heels but had mild edema to the bilateral legs and feet. An observation of Resident #22 on 04/08/21 at 9:00 AM revealed resident was lying in bed with lower extremities lying flat on the mattress with no compression stockings applied to bilateral extremities or pressure relief boots in place. Resident #22 did not have any skin breakdown to the bilateral heels or edema to the bilateral legs and feet. An interview with Resident #22 on 04/08/21 at 9:00 AM revealed an alert and oriented resident. The Resident reported staff have not put her compression stockings on or her pressure reducing boots for days. The Resident stated, "I ' m supposed to have them on every day, but they do not put them on me every day." An observation of Resident #22 on 04/08/21 at 12:30 PM revealed the resident was lying in bed with lower extremities lying flat on the mattress with no compression stockings applied to bilateral extremities or pressure relief boots in place. Resident #22 did not have any skin breakdown to the bilateral heels but had mild edema to the bilateral legs and feet.	F 684	documentation and following physicians' orders. All education will be completed by 5/6/2021. Any licensed nursing staff out on leave or PRN status will be educated prior to returning to duty by the DON and/or designee. Any newly hired licensed nurse will be educated by the Staff Development Coordinator (SDC) during orientation. Monitoring An auditing tool was developed to monitor nursing staff to ensure they are following physician orders and that tasks are actually completed. Audits will be conducted on 10 residents per week x4 weeks, then monthly x3 months. The results of these audits will determine the need for further monitoring. Audit results will be brought to the QAPI meeting by the DON monthly x 4 months and will be reviewed and analyzed by the QAPI team.	

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F 684	Continued From page 3	F 684		

An interview with Resident #22 on 04/08/21 at 12:30 PM was conducted. The resident reported the nurse has not yet applied the compression stockings or the pressure relief boots.
An observation of the Treatment Administration Record (TAR) at 2:45 PM revealed the orders for the compression stockings to bilateral legs and the pressure relief boots while in bed were signed by Nurse #6 as evidenced by her initials.

An observation of Resident #22 on 04/08/21 at 2:48 PM revealed the compression stockings to bilateral legs were not applied nor were the pressure relief boots.

An interview with Nurse #6 on 04/08/21 at 3:00 PM was conducted. Nurse #6 stated she forgot to put them on her but signed the orders off as it was done. Nurse #6 stated she did not usually sign off the tasks as completed until she completed them. Nurse #6 stated she signed off on the compression stockings on 04/07/21 also but forgot to apply the stockings.

An observation of Nurse #6 and Nurse #9 was conducted at 3:05 PM. Nurse #6 and Nurse #9 were unable to find the compression stockings or the pressure relief boots in Resident #22 ' s room. A nursing assistant (NA) went to the supply room and obtained a new pair of compression stockings and stated, "I need to find a pair of pressure relief boots." Nurse #9 observed the resident ' s lower extremities and stated they had mild edema. Both heels were observed by Nurse #9 and there was no skin breakdown or redness.

An interview was conducted with Nurse #9 on 04/08/21 at 3:05 PM. Nurse #9 reported she had not applied the pressure relief boots on 04/07/21

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F 684	Continued From page 4	F 684		

but had signed off in the TAR that she had completed the task. Nurse #9 stated she thought the resident had them on. Nurse #9 stated she did not remove the compression stockings on 04/07/21 at bedtime but had signed them off in TAR as being removed.

An interview with the Director of Nursing (DON) on 04/09/21 at 4:30 PM revealed her expectation of the nursing staff was to follow the prescribed physician orders and apply the relief boots and compression stockings as ordered. The DON stated she expected the nursing staff to not sign off on any task until the tasks were completed because this was inaccurate documentation.

2. Resident #43 was admitted to the facility on 04/18/17. Diagnoses included, in part, stroke with left side weakness.

A review of the current care plan dated 02/14/21 revealed a plan of care for self-care deficit related to upper extremity contracture as evidenced by decreased ability to care for splint or brace. Intervention included, in part, staff to apply left resting hand splint to left hand with assistance of 1 person over the review period, and staff to apply left resting hand splint to left hand on in the morning and off in the evening 5-6 days a week as tolerated. The care plan indicated to include this approach on the resident profile.

A review of the resident ' s profile (located in the electronic records) revealed, in part, on 02/14/19 apply left resting hand splint to left hand on in the morning and off in the evening once a day on Sunday, Tuesday, Wednesday, Thursday and Friday.

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F 684	Continued From page 5	F 684		

The MDS significant change assessment dated 02/16/21 revealed the resident was cognitively intact and demonstrated no refusal of care behaviors. Resident #43 had an impairment on one side to the lower and upper extremities.

A physician ' s order written on 02/14/21 revealed Resident #43 was to wear a left resting hand splint to be applied in the morning and taken off before evening.

A review of the Medication Administration Record (MAR) revealed Nurse #3 ' s initials were documented under the application of the left-hand splint which indicated "on" dated 04/07/21.

Observations of Resident #43 on 04/07/21 at 9:00 AM, 10:47 AM, 1:17 PM, 2:26 PM and 4:45 PM revealed the left-hand splint was not on her contracted left hand.

An interview was conducted with Resident #43 on 04/07/21 at 4:45 PM. Resident #43 reported she was supposed to wear a left-hand splint to her hand, but the nurse never put it on her.

An interview was conducted with Nurse #3 on 04/08/21 at 9:14 AM. Nurse #3 stated she did not apply the left-hand splint and she should not have signed it off in the medication administration record as "on" on 04/07/21.

An interview with the Director of Nursing (DON) on 04/09/21 at 4:30 PM revealed her expectation of the nursing staff was to follow the prescribed physician orders and apply the left-hand splint as ordered. The DON stated she expected the nursing staff to not sign off on any task until the tasks were completed because this was

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F 684	Continued From page 6 inaccurate documentation.	F 684		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview and staff and Physician interviews, the facility failed to follow the resident ' s care plan to utilize two staff members with bed mobility for 1 of 2 residents observed for falls. Resident #43 sustained a fall which resulted in a left fractured femur that required surgery. Findings included: Resident #43 was admitted to the facility on 04/18/17, discharged on 02/09/21 to the hospital and readmitted to the facility on 02/12/21. Diagnoses included, in part, fracture to left femur (02/09/21) and stroke with left side weakness. A care plan dated 04/19/19 and last reviewed on 02/26/21 revealed a plan of care for Activity of Daily Living (ADL) self-care deficit related to stroke with left sided hemiparesis and morbid obesity. The approach included, in part, bed mobility required assistance of two staff. The care plan indicated to include this approach on the resident profile.	F 689	Filing of this plan of correction does not constitute admission that the deficiencies alleged did in fact exist. The plan of correction is filed in evidence of the facilities desire to comply with the requirements and continue to provide a high quality of care. Failure to follow the CNA care plan (resident profile), led to the deficiency. Resident Affected Corrective action has been accomplished for the alleged deficient practice in regards to Resident #43. The care plan and resident profile for Resident #43 was reviewed by the Minimum Data Set (MDS) Coordinator on 4/29/21 to ensure both accurately reflect the resident's current level of assistance. No changes were made to the care plan or resident profile. The resident returned to the facility to her baseline with no adverse affect from the	5/10/21

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F 689	Continued From page 7 A review of the resident ' s profile (located in the electronic records) revealed, in part, on 04/04/19 bed mobility required the assistance of two staff. The Minimum Data Set (MDS) quarterly assessment dated 11/13/20 revealed Resident #43 was cognitively aware and demonstrated no moods or behaviors. Resident #43 required extensive assistance with two staff physical assistance with bed mobility and transfers. Resident #43 had impairments on one side to both lower and upper extremities and was always incontinent of bowel and bladder. A progress note written on 02/08/21 revealed Nurse #2 and Nurse #7 were called to Resident #43 ' s room at 10:20 PM on 02/07/21. The Nursing Assistant (NA #3) was present in the room giving care. The resident was observed on her knees between the bed and the wall. The bed was moved, and resident was gently assisted to a supine position. Passive range of motion was within normal limits for baseline. The resident demonstrated no facial grimacing and first aid was administered for a 0.5 centimeters (cm) abrasion to the left knee. No other injuries were noted. The resident denied any pain when asked and was transferred back to bed using a mechanical lift. She was noted to be alert and oriented, pleasant toward staff, and could make her needs known. The note indicated it was a witnessed fall by the assigned NA (NA #3). On 02/08/21, a progress note revealed Resident #43 requested the nurses to assess her hip. The resident complained of severe pain related to her fall on 2nd shift. The nurse assessed her hip and no visible abnormalities were noted. Resident	F 689	alleged deficient practice. Other Residents with Potential to be Affected Director of Nursing (DON) and/or designee observed bed mobility for all residents requiring a two person assist to ensure the care plan was followed appropriately. This was completed by 5/6/2021. No issues were observed and no other resident was affected by the alleged deficient practice. Systemic Changes DON educated Certified Nurse Assistant (CNA) #3 regarding reviewing the CNA care plan (resident profile) prior to ADL care on 5/4/2021. DON or designee will educate all nursing staff to follow CNA care plan (resident profile) when providing care for a resident. Minimum Data Set (MDS) Coordinator #1 and MDS Coordinator #2 were educated on 5/4/2021 regarding updating the CNA care plan (resident profile) with any changes in ADL assistance. All education will be completed by 5/7/2021 by the DON and/or designee. Any nursing staff out on leave or PRN status will be educated by the DON and/or designee prior to returning to duty. Newly hired CNA’s will be educated during orientation by the SDC. An auditing tool was developed to monitor nursing staff to ensure that they are following the CNA care plan (resident profile) during ADL care. DON/designee	

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F 689	Continued From page 8 #43 requested that a note be left for the physician to order an x-ray for her left hip. On 02/08/21 at 10:23 AM, Resident #43 had a new order for an x-ray to the left hip due to complaints of pain. A review of the x-ray result on 02/08/21 time stamped at 9:58 PM revealed there was a fracture of the distal femur, there was impaction, osteoporosis and knee replacement and the fibula was normal. A progress note written at 3:20 AM on 02/09/21 revealed the x-ray results were received and a call was attempted three times to the Nurse Practioner, and messages were left on the voicemail. The note indicated the Director of Nursing, Supervisor, and Power of Attorney (POA) were notified. The note stated the resident had been given pain medication at 10:00 PM and was resting comfortably with eyes close and no complaints of pain or discomfort. On 02/09/21 at 5:36 AM, a progress note revealed the resident woke up in pain and Percocet (a narcotic pain reliever) was given. The nurse sent the resident out to the emergency department for treatment and evaluation of fracture post fall. On 02/10/21 at 4:28 AM the nurse contacted the hospital to receive an update on Resident #43. The nurse was informed the resident was scheduled for surgery on 02/10/21 at 10:30 AM for left distal femur fracture. Hospital Discharge Summary on 02/12/21 revealed Resident #43 had a closed fracture of	F 689	will utilize monitoring tool to randomly audit ADL care on all 3 shifts and weekends to ensure that nursing staff are following the CNA care plan (resident profile). Audits will be conducted on 10 residents weekly x 4 weeks, then monthly x 3 months. The results of these audits will determine the need for further monitoring.	

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F 689	Continued From page 9	F 689		

left distal femur secondary to falling out of bed at facility and underwent a retrograde nailing to left femur on 02/10/21. Discharged back to facility on 02/12/21.

The MDS assessment for significant change dated 02/16/21 revealed the resident was cognitively aware and demonstrated no moods or behaviors. Resident #43 required extensive assistance with two staff physical assistance for bed mobility and transfers. Resident #43 had impairments on one side to both lower and upper extremities and was always incontinent of bowel and bladder. Resident #43 had a fall with major injury during this assessment.

A review of the revised care plan on 02/26/21 revealed a plan of care for ADL self-care deficit related to stroke with left sided hemiparesis, morbid obesity, and fractured left femur. The approach included, in part, bed mobility required assistance of two staff. The care plan indicated to include this approach on the resident profile. An interview was conducted with Resident #43 on 04/07/21 at 10:30 AM. Resident #43 reported she had a fall and fractured her left leg. The resident stated the nursing assistant was changing her and rolled her too far over on the bed and she fell on her knees. The resident reported she was supposed to have two staff members doing her incontinent care at all times. The resident reported there was only one nursing assistant changing her the night she fell.

An interview was conducted with NA #3 via phone on 04/09/21 at 11:58 AM. NA #3 reported she was assigned to Resident #43 on the night of 02/07/21. NA #3 stated she went in to change Resident #43 and when she turned her over on to

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her left side she kept rolling and she got caught between the wall and the bed. NA #3 stated the resident usually could assist with rolling and would grab the ¼ side rails whenever she was turning and repositioning, but this time she had rolled her too far over and gravity took over. The NA stated she checked in the hall for help, but no one was nearby, and the resident was squirming and moving around, and she did not want to leave her. The NA stated the resident was getting a little anxious and scared because she was lodged between the bed and the wall and she was scared she was going to fall. NA #3 stated the bed was raised about hip height and she was 5 ' 2". She stated the resident had left sided weakness and her bed was about 15 feet or so from the wall. NA #3 stated she was not able to move the resident herself so she went to the door to call for help, but there was no one available and she was acting quickly to help the resident because the resident was anxious and moving her leg around which was making the bed move some. The NA stated she called out for somebody to come help her and then the resident slowly started to fall to the floor. NA #3 stated when she started to fall she went down knee first and her left knee hit the floor first. The NA stated once the resident was on the floor, she moved the locked bed away further from the wall and added that the bed needed to be in its lowest position in order to move it freely. NA #3 reported Nurse #7 and Nurse #2 and NA #1 came running into the room and both nurses assessed the resident. NA #3 stated she only saw a skin tear on her knee, and she had no redness, bruising and no complaints of pain, but she was upset because it happened. NA #3 stated she got the mechanical lift and they all assisted her back to bed. NA #3 stated she had always done Resident

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#43 ' s bed mobility care by herself. She stated she was able to change the resident by herself because the resident could assist. NA #3 stated if she needed to learn anything new about a resident, she would ask the nurses or ask other nursing assistants. She stated she had been trained on the computer on how to retrieve information about the resident, but she was not very savvy with it and preferred to get any information she needed about the residents from the staff. NA #3 was never informed the resident needed two assist with bed mobility until after the fall had happened.

An interview was conducted with Nurse #2 via phone on 04/09/21 at 2:35 PM. Nurse #2 stated she was very familiar with Resident #43 and stated 02/07/21 at about 10:30 PM she heard a yell for help coming from Resident #43 ' s room. Nurse #2 stated when she entered the room, the resident was beside the bed on the floor on her knees. She stated NA #3 reported she was changing Resident #43 and she rolled the resident too far over onto her left side and the resident became lodged between the bed and wall and then fell to the floor. NA #3 stated the resident was able to reposition herself with help and could hold onto the ¼ side rails once you got her started to a rolling position. Nurse #2 stated that she and Nurse #7 and the two NAs that were present in the room repositioned the resident on to her back and assisted her on the mechanical lift after she was assessed by herself and Nurse #7. Nurse #2 stated she had no complaints of pain, range of motion was within normal limits, no bruising or redness was noted except for a skin tear to her left knee that was cleaned and dressed. Nurse #2 stated the resident requested a snack and she provided one for her. Nurse #2

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stated she had seen only one NA doing care on her, but she believed Resident #43 required assistance of two staff and stated it would be documented in her care plan how many staff were needed to assist her.

An interview was conducted with Nurse #3 on 04/08/21 at 12:45 PM. Nurse #3 stated Resident #43 needed two staff members to do all her care since her fall on 02/07/21, and prior to 02/07/21, she required two staff members to assist with transfers and bed mobility. Nurse #3 stated the information of how the resident needed to be transferred was noted in the resident ' s care plan.

An interview was conducted with NA #4 on 04/08/21 at 1:55 PM. NA #4 stated she had been in serviced regarding turning and repositioning after the resident had a fall on 02/07/21. NA #4 reported she was educated to have two people assisting with all care. NA #4 stated she last took care of Resident #43 on 04/05/21 and she completed the care alone including bed mobility and stated she was able to do the residents ' care with no difficulty without a second person. NA #4 stated if she needed to know how many staff were required with assistance with a resident she would look in the Kardex. NA #4 attempted to find the Kardex book and asked a nurse nearby who stated, "We do not use the Kardex anymore, the information was in the electronic record under Resident Profile." NA #4 stated she would ask another NA or a nurse how many staff were required to assist residents if she did not know.

An interview was conducted with the Director of Nursing (DON) on 04/09/21 at 3:53 PM via

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F 689	Continued From page 13 phone. The DON reported she was aware the care plan and the MDS indicated Resident #43 required the assistance of two staff with bed mobility, but she added, the resident was able to help with repositioning by holding on to the ¼ rails once she had been assisted to roll on to her side so one person was able to do care. The DON stated she felt it was a freak accident. The DON reported she did not know if the fall could have been avoided if there were two staff present while doing care. An interview was conducted with the attending Physician via phone on 04/09/21 at 4:02 PM. The Physician stated he cared for the resident ' s fractured femur when she was at the hospital post fall. The Physician stated if she was care planned for two staff to assist with bed mobility then she should have had two people assisting her. An interview with the Administrator on 04/09/21 at 4:15 PM revealed her expectation of the nursing staff was to follow the care plan for bed mobility to ensure the safety of the resident	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or	F 692		5/10/21

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F 692	Continued From page 14 desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review, staff and Nurse Practitioner interviews, the facility failed to identify and implement inventions to prevent significant weight loss for 1 of 2 sampled residents (Resident #223). Findings included: Resident #223 was admitted to the facility on 01/08/21 and discharged to the hospital on 02/23/21. Diagnoses included thyroid disorder, dementia, malnutrition, anxiety, depression, and history of anorexia nervosa. The Minimum Data Set admission assessment dated 01/15/21 revealed the resident was cognitively impaired and demonstrated behaviors such as physical and verbal behaviors toward others and rejection of care. Resident #223 required extensive assistance with one staff physical assistance with eating. The resident ' s weight was 109 pounds, she was on a mechanically altered diet and had no difficulty with swallowing. A review of the care plan dated 01/11/21 revealed	F 692	Filing of this plan of correction does not constitute admission that the deficiencies alleged did in fact exist. The plan of correction is filed in evidence of the facilities desire to comply with the requirements and continue to provide high quality of care. Resident Affected Resident #223 no longer resides in the facility. Others Residents with the potential to be affected All current resident weights were reviewed by the Director of Nursing (DON) and/or designee on 5/3/2021. Any resident with at least a 5 lb weight loss from most recent documented weight was re-weighed to ensure accuracy. Any identified residents with unintentional weight loss of at least 5 lbs from most recent weight will be referred to the dietitian for review and recommendations.	

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F 692	Continued From page 15 the resident had a plan of care to maintain adequate nutrition status as evidenced by maintaining weight with no signs or symptoms of malnutrition and consuming food at least 50% of three meals per day through the next review. Interventions included, in part, one on one assist with meals as needed due to dementia, provide and serve supplements as ordered, provide red scoop plate for all meals for ease of self-feeding, and obtain monthly and as needed weights. A review of the Registered Dietician (RD) note written on 01/15/21 revealed Resident #223 was admitted to the facility on 01/08/21. Current diet was regular with pureed texture and her current body weight was 109 pounds. The note indicated the resident ' s oral intake was good, but variable. The resident was able to feed herself with cues but was fed by the staff when her appetite was poor. A review of the physician orders written on 01/08/21 revealed the following micronutrient supplemental orders were in place for Resident #223: Vitamin B-12 1000 micrograms (mcg) one tablet by mouth daily in the evening Magnesium Oxide 400 milligrams (mg) one tablet by mouth daily in the evening Potassium Chloride 20 milliequivalents one tablet by mouth twice daily Remeron (appetite stimulant) 15 mg give 7.5 mg one tablet by mouth daily in the evening Vitamin D3 126 mcg one tablet daily in the morning A review of the resident ' s weight revealed the resident weighed 109 pounds upon admission on	F 692	Interventions were put into place for residents with a confirmed 5 lb weight loss as appropriate. This was completed on 5/5/2021. There were 5 other residents identified through this process and each were re- weighed and referred to the Registered Dietitian. The MD/NP was updated as well by the DON. Systemic Changes The DON and/or designee will educate all nursing staff regarding the importance of accurate weight documentation and notification of weight losses of 5 lbs or more. All nursing staff will also be educated on the process for obtaining and documenting weights. This education will be completed by 5/7/2021. Any nursing staff out on leave or PRN status will be educated by the DON/designee prior to returning to duty. Any newly hired nursing staff will be educated during orientation by the Staff Development Coordinator. Unit Coordinators will be educated by the DON regarding the process of obtaining and documented weights. This will be completed by 5/6/2021. Monitoring An auditing tool was developed to monitor residents' weights. DON and/or designee will review 10 resident’s most current weight weekly to ensure accuracy of documentation, notification and implementation of interventions as appropriate. Audits will be completed on each resident 2x per week for 4 weeks,	

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F 692	Continued From page 16 01/08/21 and decreased to 104 pounds on 01/21/21. On 01/29/21 the resident ' s weight decreased to 100.8 lbs. The weights were recorded as follows since 01/29/21: 01/29/21 at 7:37 PM weight was recorded as 100.8 lbs. 02/08/21 at 10:55 AM weight was recorded at 101 lbs. Recorded by Unit Coordinator (UC) #2. 02/19/21 at 1:56 PM weight was recorded as 86.6 lbs. Recorded by Nursing Assistant (NA) #3. 02/19/21 at 1:57 PM weight was recorded as 86.6 lbs. Recorded by Nurse #1. An interview with Nurse #4 on 04/06/21 at 2:20 PM revealed when a resident was newly admitted to the facility, the staff would obtain a weight and height. Nurse #4 stated he would not use the weight from the hospital discharge summary, and he would make sure to get a new weight at the facility. Nurse #4 stated he obtained Resident #223 ' s weight on admission on 01/08/21 and it was 109 pounds. An interview was conducted with Nurse #1 on 04/06/21 at 3:04 PM. Nurse #1 reported she did not recall documenting Resident #223 ' s weight on 02/19/21, but confirmed her name was documented beside the weight that was obtained on 02/19/21 at 1:57 PM. Nurse #1 denied taking care of the resident on 02/19/21 and stated that sometimes another nurse would ask her to put weights in the charts. Nurse #1 stated if there was a significant weight loss of 5 lbs. or more, the protocol was for the nurse to notify the Unit Coordinator, the Physician, and the Responsible	F 692	then weekly for 4 weeks, then monthly x 3 months. The results of these audits will determine the need for further monitoring. Audit results will be brought to the QAPI committee by the DON motley x 4 months and will be reviewed and analyzed by the QAPI team.	

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Party and to also request the resident be reweighed. Nurse #1 stated she did not recall notifying any family, the Physician, or the Unit Coordinator because she did not know the resident even had a weight loss. The nurse stated there was no way of telling what the previous weight was for a resident after the nurse obtained a current weight. Nurse #1 stated she noted NA #4 had documented the weight of 86.6 pounds at 1:56 PM and she was associating the weight of 86.6 pounds in the electronic record. Nurse #1 stated when a nurse associated a weight in the electronic health record it meant they were aware of the weight that was obtained that day by the NA. Nurse #1 stated she did not request a reweigh for Resident #223.

An interview was conducted with the Registered Dietician (RD) on 04/06/21 at 2:10 PM. The RD stated she was not aware of the 15-pound weight loss. The RD stated, up until about a month ago, she would have waited to be notified by staff to inform her of any weight loss until she learned about a weight variance report that was generated from the electronic health record which gave a picture of all the weight loss and weight gains and the percentages. The RD reported the resident was being followed in the Interdisciplinary Team (IDT) meetings and she believed the resident was on nutritional supplements but when the RD reviewed the resident ' s orders, the RD stated she was only on the micronutrient supplements. The RD stated had she been aware of the 15-pound weight loss she would have ordered nutritional supplements. The RD stated the resident had a history of anorexia nervosa, but her weight had been stable around 100 - 104 pounds. She stated the weight loss from 100 to 86.6 pounds was a significant

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weight loss and should have been addressed. The RD stated she noticed the weight loss from 109 pounds to 104 pounds and was not overly concerned due to the resident being new to the facility and often residents would have a decrease in weight when they were new to the facility until they get acclimated.

An interview was conducted with NA #1 on 04/06/21 at 4:22 PM. NA #1 reported Resident #223 was alert and would require assistance with feeding at times. NA #1 stated the resident would have her good days and bad days. She reported the resident ate 75% to 100% of her meal at breakfast, then she would only eat about 25% at lunch and then have about 50% with dinner. NA #1 stated when the resident was done, she would not let you feed her anymore, and state "no that ' s it, I don ' t want anymore." NA #1 stated that her oral intake would vary day to day. NA #1 stated she would notify the nurse of how much the resident consumed and documented the percentage in the computer system.

An interview was conducted with the Speech Therapist (ST) on 04/07/21 at 1:42 PM. The ST stated whenever there was a significant weight loss for a resident ST would be notified by the IDT team so that a speech evaluation could be conducted to see if the weight loss was as a result of any swallowing difficulties. The ST stated the resident was being followed by ST up until 02/07/21 and the resident had advanced dementia and her participation depended on the day. The ST reported due to the dementia, the resident had poor attention at task, but she had no swallowing difficulties and did well with thin liquids.

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An interview was conducted with the Unit Coordinator (UC) #2 (a nurse on the 300 hall) on 04/08/21 at 11:15 AM. The UC #2 stated the nurses were instructed to notify the Unit Coordinators of any weight loss or gains and the UC ' s would document the weight in the computer system. UC #2 reported she was not made aware of the weight loss of 15-pound for Resident #223. UC #2 stated if she had known about the weight loss she would have notified the Physician and would have brought that concern to the IDT meeting for further discussion and interventions. UC #2 reported the nurses had access in the computer system to check the previous recorded weight.

An interview was conducted with the Nurse Practioner (NP) #1 via phone on 04/08/21 at 12:28 PM. The NP stated he did not recall being notified Resident #223 had a significant weight loss, but, he added, if he had the knowledge of the weight loss, he would have ordered a nutritional supplement. NP #1 stated he was not certain the nutritional supplement would have helped given her dementia which causes decreased appetite and weight loss.

An interview was conducted with Nursing Assistant (NA) #4 on 04/08/21 at 1:55 PM. NA #4 reported the nurses would inform her if a weight was due on a resident at the start of her shift. NA #4 stated Resident #223 was weighed in a wheelchair which was rolled on to the scale. NA #4 stated she would deduct the amount of the wheelchair which was 26.2 lbs. and then document the weight in the computer system and notify the nurse of the weight. NA #4 stated the nurse would request a reweigh on the resident if there was a significant loss or gain. NA #4 stated

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F 692	Continued From page 20 Nurse #1 never asked her to get a reweigh on Resident #223 on 02/19/21. NA #4 reported she has fed Resident #223 for meals in the past, but sometimes the resident would eat fine on her own. NA #4 stated she would eat at least 50% with her breakfast and lunch. NA #4 stated, at times, the resident needed encouragement and cueing to eat and that seemed to work, but other times it did not seem to work, and she would not eat. NA #4 stated Resident #223 had good days and bad days. NA #4 stated she would notify the nurse of the Resident ' s oral intake for breakfast and lunch and document the percentage in the computer system. An interview was conducted with the Director of Nursing (DON) on 04/09/21 at 4:30 PM. The DON reported her expectation of the nursing staff was to notify the family, the Physician and the Nursing Supervisor of any significant weight loss or gains so the resident could be further assessed and interventions to prevent weight loss could be implemented.	F 692		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, staff, and Physician interviews the facility failed to prevent a significant medication error by not following the hospital discharge orders resulting in failure to administer 45 doses of a medication used in the treatment of Parkinson's Disease for 1 of 10 residents (Resident #273) whose Medication Administration	F 760	Filing of this plan of correction does not constitute admission that the deficiencies alleged did in fact exist. The plan of correction is filed in evidence of the facilities desire to comply with the requirements and continue to provide a high quality of care.	5/10/21

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F 760	Continued From page 21 Record was reviewed. Findings included: Resident #273 was admitted to the facility on 01/22/21 with diagnoses to include in part, Progressive Parkinson's Disease. He was discharged home on 02/07/21. A review of the hospital discharge summary dated 01/22/21 documented Resident #273 had progressive neurocognitive and physical decline secondary to Progressive Parkinson's Disease. During the hospital course, Neurology evaluated and ordered to start Comtan (entacapone-prescribed for treatment of Parkinson's disease as an adjunct to levodopa and carbidopa therapy), to continue Sinemet (carbidopa-levodopa - a dopamine precursor prescribed to treat the symptoms of Parkinson's Disease). Avoid benzodiazepines and continue Seroquel (an antipsychotic medication) for agitation and restlessness. The hospital discharge medication orders dated 01/22/21 included in part, to continue Carbidopa/Levodopa (Sinemet) 25/100 mg (milligrams) per tablet, with instructions to take two tablets by mouth three times a day at 8:00 AM, 12:00 PM, and 4:00 PM. Take Entacapone (Comtan) 200 mg by mouth four times a day, and Quetiapine (Seroquel) 50mg by mouth a bedtime. A review of the Medication Administration Record (MAR) from admission on 01/22/21 through date of discharge on 02/07/21 revealed no entry for Sinemet 25/100 mgs for treatment of Parkinson's Disease for Resident #273. A review of the physician orders from 01/22/21	F 760	Affected Resident Resident #273 suffered no ill effects from the alleged deficiency. Others residents with the potential to be affected The Director of Nursing (DON) and/or designee audited admission orders for residents admitted within the last 30 days to ensure that all admission orders were transcribed into the electronic health record (EHR) accurately. This will be completed by 5/6/2021 and no other residents were adversely affected by the alleged deficient practice. Systemic Changes The DON and/or designee educated all licensed nursing staff regarding the admission process as it relates to order entry and the verification process. The process is that the admitting nurse reviews the discharge summary orders, verifies with the physician and/or Nurse Practitioner (MD/NP). Once verified, the nurse the enters the orders into the electronic health record, prints them and has another nurse verify that the orders have been transcribed accurately. They both sign orders and then the MD/NP signs. This is then checked in morning meeting by the Director of Nursing and/or designee. This was completed by 5/6/2021. Any licensed nursing staff out on leave or PRN status will be educated	

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F 760	Continued From page 22 through 02/07/21 revealed no order for Sinemet 25/100mgs for Resident #273. The facility copies of the hospital discharge summary dated 01/22/21 were provided by the Unit Coordinator (#2). The summary of medications had check marks notated after each medication listed with the facility Nurse Practitioners signature indicating the medication was reviewed. There was no check mark indicating the Sinemet 25/100 mgs was reviewed, and no comment to continue or discontinue the medication after the Nurse Practitioner completed the review. A review of the Minimum Data Set (MDS) admission assessment dated 01/29/21 revealed Resident #273 was cognitively intact. He exhibited no behaviors, and no rejection of care. He required extensive one-person assistance with bed mobility, walking, dressing, and personal hygiene, and required extensive two-person assistance with transfers. He had no impaired range of motion, and utilized a walker and wheelchair for mobility, with no falls since admission. He received Physical, Occupational, and Speech therapy services during his stay in the facility. A review of the facility Nurse Practitioner's progress note dated 02/05/21 at 8:53 AM, read in part, Resident #273 was in his wheelchair in room and in good spirits as he was being discharged home on 02/06/21. He fully participated in therapy. He had not fallen since admission. He leaves in fair condition. An interview was conducted with Unit Coordinator (#2) on 04/08/21 at 9:11 AM. She stated Resident	F 760	prior to returning to duty by the Staff Development Coordinator (SDC). New hired licensed nursing staff will be educated by the SDC during orientation. Monitoring An auditing tool was developed to monitor the admission process as it relates to the accuracy of order entry and verification of orders. This audit will be completed by the DON and/or designee within 72 hours of admission. This audit will be completed on all admissions for 12 weeks. The results of these audits will determine the need for further monitoring. Audit results will be brought to the Quality Assurance Performance Improvement (QAPI) meeting by the DON monthly x 3 monthly and will be reviewed and analyzed by the QAPI team.	

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#273 was admitted for short term rehab and required extensive assistance with care. She reported he needed encouragement to participate in care and therapy but met his goals by the time of discharge. She stated during the admissions process the Nurse Practitioner reviewed the hospital discharge orders including medications and would notate on the discharge summary to continue or discontinue the medication. Once the Nurse Practitioner completed a review, two nurses reconciled the orders and the nurse, or the unit manager entered the medications into the EHR (electronic health record). She reported two nurses were required to review the medication orders after the Nurse Practitioner signed off the orders to prevent transcription errors.

During a follow up interview with Unit Coordinator (#2) on 04/08/21 at 11:37 AM, she stated she reviewed the hospital discharge summary for Resident #273 and agreed the Nurse Practitioner did not sign off on the Sinemet 25/100 mgs and did not indicate whether to continue or discontinue the medication. She reported after reviewing the summary it appeared the Nurse Practitioner missed the medication and agreed that the two nurses that reconciled the medication orders also missed the Sinemet order and therefore it was not entered into the electronic health record. She stated she may have been one of the nurses that signed off the orders, she did not recall and if so, it was an error on her part. She agreed staff should have recognized the discrepancy and clarified the Sinemet order during the reconciliation process.

An interview was conducted on 04/08/21 at 2:58 PM with the Director of Nursing (DON). She stated there was a system in place, which

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included an admission check list sheet, to make sure orders were signed by the Nurse Practitioner, then reconciled by two nurses, and then entered on the MAR during the admission process. She indicated her expectation was that the medications were reconciled and transcribed accurately to the electronic medical record.

An interview was conducted on 04/08/21 at 3:06 PM with the Occupational Therapist. She stated Resident #273 received all three services Physical, Occupational, and Speech therapy during his stay. She reported the resident was at substantial-maximum assist meaning resident performed 25% and staff performed 75% of activity. Therapy tried to get him to moderate assist with 50-50 effort, but he was still at maximum assist at discharge. She reported they weren't getting much progress, but the resident consistently maintained his level of functioning with no decline in rigidity from admission to discharge. She stated he had no decline from a therapy standpoint and was discharged at the level of maintaining function, with no decline.

A phone interview was conducted on 04/15/21 at 9:33 AM with the facility Medical Director. He stated he evaluated Resident #273 once, and then the resident was discharged home. He stated he found out after the fact that the medication was missed. He reported he reviewed the hospital discharge summary after he received notification from the facility of the missed medication and stated the hospital discharge summary was sort of unusual regarding how the discharge packet was put together, resulting in the Sinemet order being the only medication listed on a page. The physician stated three staff members missing the order was a complete

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system failure and stated he couldn't explain why a total system failure occurred. He stated, abruptly stopping Sinemet would not cause harm, but it may decrease mobility, and would not cause harm as far as cardiac, pulmonary, or withdrawal symptoms. He stated no harm occurred with Resident #273, he maintained his level of functioning, and he was also on Entacapone four times daily during his time in the facility. He stated Resident #273 did not progress in functioning but had no decline.

A follow up phone interview was conducted on 04/15/21 at 1:40 PM with the Administrator along with the Director of Nursing. The DON stated the nurses that reconciled the medication orders go by what the facility Nurse Practitioner signed off on, and that's how it was missed. The Administrator stated on admission the hospital discharge orders were printed out, the Nurse Practitioner reviewed the orders and signed off, then two nurses were required to double check and transcribe the orders, and stated the admission checklist included, in part, observations, with skin checks, the baseline care plan, and verification of the medications orders. The DON stated the two nurses that signed off on Resident #273's hospital discharge orders were the unit coordinators (UC #1 & UC #2).

A phone interview was conducted on 04/15/21 at 3:37 PM with Unit Coordinator #1, along with the DON. The Unit Coordinator stated the Nurse Practitioner gets the hospital discharge packet with orders, then signs off on the orders to be continued, the nurse enters the orders in the computer, then printed out a list of the medication orders that were entered, the next day two nurses reviewed the list to make sure the orders were

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F 760	Continued From page 26 entered accurately. She stated the printed orders go back to the Nurse Practitioner a final time to make sure the orders were accurate. She reported she signed off on the orders for Resident #273 according to what the Nurse Practitioner signed off on. The DON added that she received a report from the hospital rehab department indicating Resident #273 was not making progress and was not meeting criteria and was referred out to skilled nursing.	F 760		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to a) discard 20 out of 30 green peppers that were spoiled and; b) failed to put an open date on 4 out of 6 thickened liquid	F 812	Filing of this plan of correction does not constitute admission that the deficiencies alleged did in fact exist. The plan of correction is filed in evidence of the	5/10/21

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F 812	Continued From page 27 containers that were opened and indicated to use within 7 days after opening. Findings included: a) During an initial tour of the kitchen with the Dietary Manager (DM) on 04/05/20 at 12:20 PM an observation in the walk-in refrigerator revealed there were 20 out of 30 green peppers noted to be spoiled which were stored in a cardboard box. An interview with Dietary Manager on 04/05/20 at 12:20 PM revealed he was the one responsible for removing any spoiled or expired products from the walk-in refrigerator. He stated he checked the walk-in refrigerator daily to ensure there were no expired or spoiled items, but he must have overlooked the spoiled peppers. b) During an initial tour of the kitchen with the Dietary Manager on 04/05/20 at 12:30 PM, an observation of the reach-in refrigerator there were noted to be two 46 ounce thickened liquid orange juice containers and two 46 ounce lemonade flavored thickened liquid drink containers that were noted to be opened, but the containers were not labeled to indicate when they were opened. The containers indicated the contents were good for 7 days after opening. An observation of posted signage was noted on the bulletin board in the kitchen area that all products that have been opened must be labeled with the date that the items were opened. An interview was conducted with the Dietary Manger on 04/05/20 at 12:30 PM. The DM reported any dietary staff that opened the thickened liquids were instructed that there must	F 812	facilities desire to comply with the requirements and continue to provide a high quality of care. Affected Residents Corrective action has been accomplished for the alleged deficiency in regards to the spoiled bell peppers and undated thickened liquids. The spoiled bell peppers and undated thickened liquids were immediately removed from the walk in refrigerator by the Dietary Manager and discarded on 4/5/2021. No residents were adversely affected by the alleged deficient practice. Others Affected The Dietary Manager completed an audit of the walk in and reach in refrigerators on 5/6/2021 to ensure all opened items are dated and any spoiled items are discarded. Any undated or spoiled food was immediately discarded. No residents were adversely affected by the alleged deficient practice. Systemic Changes The Dietary Manager educated all dietary staff regarding the process for dating food items when opened to ensure they are used or discarded within 7 days of opening. The Dietary Manager also educated all dietary staff regarding disposing of spoiled items when identified. This education was completed on 5/6/2021. Any dietary staff out on leave or	

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F 812	Continued From page 28 be an open date recorded on the container when the container was opened. The DM stated since the product was only good for 7 days after opening, it was necessary to be sure the product had an open date on it so the dietary staff would know if the product was within its time parameter to serve. An interview was conducted with the Administrator on 04/05/21 at 4:30 PM. The Administrator stated her expectation of the Dietary Manager and the dietary staff were to monitor the walk-in refrigerator for any expired or spoiled food products and to ensure that they were following the protocol to date all items when they were opened to guarantee the freshest foods were served to the residents.	F 812	PRN status will be educated by the Dietary Manager prior to returning to duty. Any newly hired dietary staff will be educated during orientation by the Dietary Manager and/or designee. Monitoring An auditing tool was developed to monitor items in the walk in and reach in refrigerators to ensure their freshness and to ensure items were dated. This auditing tool will be completed by the Dietary Manager 3 times per week for 4 weeks, then weekly for 4 weeks then monthly for 2 months. The results of the audits will determine the need for further monitoring. Audit results will be brought to the Quality Assurance Performance Improvement (QAPI) meeting by the Dietary Manager monthly for 4 months and will be reviewed and analyzed by the QAPI committee.	
F 880 SS=D	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	F 880		5/10/21

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F 880	Continued From page 29 a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, 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.	F 880		

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F 880	Continued From page 30 §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 observation, staff interviews, and record review staff failed to implement the facility's COVID-19 Plan and Protocols for wearing the personal protective equipment (PPE) required for 1 of 2 staff (NA #4) observed providing care and services to 3 of 4 residents (Resident #72, #70, and #57) who were quarantined and on enhanced observation droplet isolation precautions. These failures occurred during the COVID-19 pandemic. Findings included: The Centers for Disease Control (CDC) recommendation titled: "Preparing for COVID-19 in Nursing Home" (last updated June 25, 2020) recommends. "If the facility has a quarantine (observation) unit which is used for new admissions or re-admissions whose COVID status is unknown. These residents should remain on observation for 14 days and CDC recommends healthcare personnel wear all recommended Personal Protection Equipment (PPE) when caring for these residents which	F 880	Filing of this plan of correction does not constitute admission that the deficiencies alleged did in fact exist. The plan of correction is filed in evidence of the facilities desire to comply with the requirements and continue to provide a high quality of care. Residents Affected Corrective action has been accomplished for the alleged deficient practice in regards to residents #72, 70, and 57 by immediately removing NA #4 from the floor. Residents #72, 70 and 57 had no adverse effects from staff entering the room without donning and doffing PPE appropriately. Others Affected Other residents who are on transmission based precautions have the potential to be affected by the alleged deficient	

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F 880	Continued From page 31 would include gown, gloves, N-95 mask (if available) and eye protection (this would be contact + droplet + eye protection)." Therefore, CDC recommends: "For residents placed on an observation or quarantine unit, Health Care Provider (HCP) entering the resident's room should wear mask, gloves, gown, and eye protection." Review of the facility's Isolation/Quarantine Policy for COVID-19 (revised 04/01/21) revealed, "All unvaccinated new admissions/readmissions will be placed on isolation unit for 14 days in a private room if Covid status negative or unknown. Resident will be placed on enhanced droplet precautions." Facility's PPE guidelines for Health Care Personnel (HCP) working on the Quarantine hall included: "N95 surgical facemask and eye protection, gloves for contact with patient or their environment, isolation gown, remove PPE, and perform hand hygiene when leaving care area." During an entrance conference conducted by the team coordinator on 04/05/21, the Administrator indicated the back 300 hall was designated as the quarantine hall for new admissions and readmissions. The Administrator stated there were no positive COVID-19 cases in the facility. During an observation on 04/08/21 at 12:30 PM Nurse Aide (NA) #4 entered rooms #325, #326, and #327 on the quarantine hall with only a face mask and gown on. NA #4 was observed as she passed out residents' meal trays and exited their rooms. NA #4 did not have gloves or eye protection on and wore the same gown in all three rooms. NA #4 was observed to exit the 300-hall quarantine hall barrier, still wearing a gown, which she then removed in the middle of	F 880	practice. The Staff Development Coordinator/Infection Prevention Nurse audited other staff to ensure proper donning and doffing of PPE when required. This was completed on 5/5/2021. No other issues regarding donning and doffing of PPE were identified. Systemic Changes NA #4 is no longer employed at the facility. The Staff Development Coordinator/Infection Preventionist educated all facility staff on reading the signage posted on residents doors and following the directions related to appropriately donning and doffing of PPE for residents on transmission based precautions. This education was completed by 5/5/2021. The policy titled “Infection Control Precaution” dated March 2020 was reviewed by the Corporate Clinical Manager on 5/5/2021. No changes were indicated. Monitoring An audit tool is being utilized to monitor staff compliance with donning and doffing of PPE when caring for residents on transmission based precautions. Audits will be conducted by the DON or designee at random, including off shifts and on weekends, 5 times per week for 4 weeks, then 2 times per week for 4 weeks, then weekly for 4 weeks. Ongoing audits will be	

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F 880	Continued From page 32 the 300-hall. When asked why she was not wearing a N95 mask, eye protection, or gloves. NA #4 responded that she did not need to, since there were no COVID-19 residents in the facility. Signage for enhanced droplet isolation was observed on all 4 of the 4 quarantine residents' doors, as well as posted on the barrier entrance to the quarantine hall. The signage indicated gown, eye protection, and N95 mask to be donned prior to entering residents' rooms. NA #4 was observed as she exited 3 resident rooms without gloves, eye protection, N95 mask, sanitizing her hands, or removing her gown prior to exiting the rooms. During an interview with NA #4 on 04/08/21 at 12:40 PM, she stated she was not aware she needed to wear full PPE, including a N95 mask, because there were no COVID positive residents' in the facility. NA #4 added she knew all four residents on the quarantine hall were on enhanced droplet isolation precautions. She confirmed she wore the same gown in all 3 residents' rooms and did not have gloves or eye protection on. NA #4 also added she should have removed her gown in resident's room and not on the 300-hall. During an interview on 04/08/21 at 12:50 PM with the Central Supply Coordinator he reported the facility had adequate PPE on hand: which currently included 1500 gowns, 900 N95 masks, 10 cases of gloves, and 10 cases of eye protection. He stated if NA #4 needed a N95 mask, all she had to do was to go to the 300-hall nursing station a pick one up. During an interview on 04/08/21 at 12:55 PM with Nurse #4 he reported NA #4 should have worn	F 880	determined by the prior 4 weeks of auditing. Audit results will be brought to the Quality Assurance Performance Improvement (QAPI) meeting by the DON monthly x 4 months and will be reviewed and analyzed by the QAPI team.	

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gloves, N95 mask, and worn one gown per room, when she passed lunch trays and did not.
During an interview on 04/08/21 at 1:05 PM with the Infection Control Preventionist (ICP) it was revealed NA #4 had just completed the facility's PPE Competency dated 03/11/21, which included PPE donning, doffing, and how to perform proper hand hygiene. He stated NA #4 knew the facility's PPE procedures, and knew where and when to don and doff PPE, which competency was required for all staff to demonstrate prior to working on the quarantine hall.

During an interview on 04/08/21 at 1:00 PM with the 300-hall Unit Coordinator #2 she reported NA #4 should have worn a gown, gloves, N95 mask, and eye protection when she took lunch trays into the residents' rooms on the quarantine hall. She added, NA #4 should not have removed her gown in the hall by the tray cart.

During an interview on 04/08/21 at 1:05 PM with the Administrator she stated staff entering rooms of residents on enhanced droplet isolation were to don full PPE prior to entering the rooms. Administrator also added that it was her expectation that all facility employees and vendors would follow all the facility's infection control policies and procedures.

During an interview on 04/08/21 at 1:30 PM with the Director of Nursing (DON) she stated staff entering rooms of residents on enhanced droplet isolation were to don full PPE prior to entering the rooms, which included wearing a N95 mask, eye protection, gloves, and gown. DON also added that it was expected that staff perform hand hygiene prior to entering and exiting an enhanced precaution room, and to dispose of all PPE inside

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345537	A. BUILDING _____ B. WING _____	C 04/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-WILMINGTON, INC	2305 SILVER STREAM LANE WILMINGTON, NC 28401

(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
F 880	Continued From page 34 the resident's room prior to exit, except for their eye protection and masks.	F 880		