STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345063	A. BUILDING _____ B. WING _____	C 04/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT WILSON	1804 FOREST HILLS ROAD W WILSON, NC 27893

(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 4/12/2021 through 4/16/2021. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # BIYI11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation was conducted from 4/12/2021 through 4/16/2021. Event ID #BIYI11. 1 of the 20 complaints was substantiated resulting in a deficiency.	F 000		
F 550 SS=D	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 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.	F 550		5/11/21

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

Electronically Signed | 05/08/2021

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F 550	Continued From page 1 §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 record review, observations, resident and staff interviews, the facility failed to promote dignity by failing to provide a privacy cover for the urinary catheter bag for 2 of 4 residents reviewed for catheters. (Resident #60, Resident #54) Findings included: (1) Resident #60 was admitted 3/12/2021, and his diagnoses included neuromuscular dysfunction of the bladder. The admission Minimum Data Set (MDS) dated 3/16/2021 and the quarterly MDS dated 4/2/2021 revealed Resident #60 was cognitively intact and had an indwelling catheter. An indwelling urinary catheter was a focus for Resident #60 ' s care plan dated 3/30/2021, and interventions included the indwelling catheter bag to be in a privacy bag.	F 550	F550 On 4/15/2021 Director of Nursing provided a privacy covering for resident #60 and #54. Current residents that has an order for an indwelling catheter were audited by the unit manager and Director of Nursing on 4/16/2021. To ensure protective coverings were in place. Any identified areas of concerns were immediately corrected by the unit manager. An in-service was initiated on 4/16/2021 by the Director of Nursing on: 1) all catheter bags must have a protective covering to ensure the resident has a dignified existence, self-determination, and communication with and access to persons and services inside and outside	

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F 550	Continued From page 2 On 4/12/2021 at 6:30am, Resident #60 ' s urinary catheter bag was observed hanging on the right side of the bed with the back of the catheter bag facing the hallway. Resident #60 was located in room B4 with the door open to the hallway. On 4/12/2021 at 9:03am during an interview with Resident #60 with his open closed, his privacy bag covering was observed laying on the night stand. On 4/12/2021 at 12:45pn, Resident #60 was observed sitting in the wheelchair inside his room with the door open with a blue cover tied to cover the urinary catheter bag. On 4/14/2021 at 9:48am, Resident #60 was located in room A8 Bed B. Resident #60 ' s urinary catheter bag was observed from the hallway facing the roommate ' s bed and the hallway with yellow urine in the urinary catheter bag. A blue urinary catheter bag covering with ties was observed lying on the floor under the bed. When asked if the urinary catheter bag not being covered bothered him, he stated, "Yes, it ' s embarrassing." On 4/14/2021 at 2:30PM, Resident #60 was observed with a visitor in the dining room with a privacy cover on the urinary catheter bag. On 4/16/2021 at 1:48pm, Nurse Aide #10 stated Resident #60 ' s urinary catheter bag was to be covered for privacy. On 4/16/2021 at 4:13pm in an interview with the Director of Nursing, he stated the urinary catheter bag was to be covered with a privacy covering to provide dignity.	F 550	of the facility to include the use of providing privacy coverings for catheters. To be completed by 5/11/2021. Director of Nursing and unit manager will audit residents with catheter drainage bags to ensure privacy coverings are over urinary catheter bags. The audit findings be documented on the Foley Catheters Audit Tool. The audits will be completed daily X 1 Week; weekly X 7 weeks; ; and then monthly X 1 month. Administrator will review results of the Foley Catheter Audit Tool. Director of Nursing or Administrator will complete a summary of the audit results and present to the QAPI committee for review and recommendations for any modifications of the monitoring process X 3 months.	

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F 550	Continued From page 3	F 550		

On 4/16/2021 at 4: 32pm in an interview with the Administrator, she stated all urinary catheter bags were to be covered for privacy with a privacy cover.

(2) Resident #54 was admitted on 3/12/2021, and diagnoses included end stage renal disease, neurogenic bladder and obstructive uropathy.

The admission Minimum Data Set (MDS) dated 3/16/2021 revealed Resident #54 was cognitively intact and had an indwelling catheter.

The care plan dated 4/1/2021 revealed a focus for an indwelling catheter and interventions included to place catheter bag in a privacy bag.

On 4/12/2021 at 6:32am, Resident #54 ' s door was open to the hallway, and a urinary catheter bag with yellow urine was observed hanging on the left side of the bed facing the hallway. No privacy bag was observed in the room. Resident #54 was located in the first resident room to the left when entering the hallway from the front lobby.

On 4/12/2021 at 7:45am, Resident #54 ' s door was open to the hallway and a urinary catheter bag was observed without a privacy covering facing the hallway on the left side of the bed with yellow urine in the bag. Nurse Aide #7 was observed entering the room to administer Resident #4 a bath before resident left for dialysis.

On 4/13/2021 at 10:40am, A privacy covering was observed on Resident #54 ' s urinary bag.

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F 550	Continued From page 4 On 4/15/2021 at 10:41am in an interview, Nurse #4 stated the urinary bag cover that tied would come off, so she changed the privacy cover on Monday, 4/12/2021. On 4/16/2021 at 4:13pm in an interview with the Director of Nursing, he stated the urinary catheter bag was to be covered with a privacy covering to provide dignity. On 4/16/2021 at 4: 32pm in an interview with the Administrator, she stated all urinary catheter bags were to be covered for privacy with a privacy cover.	F 550		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to assess the ability of a resident to safely self-administer oral medications that were observed on the resident's over the bed table for 1 of 1 resident reviewed for self-administration of medications (Resident #55). The findings included: Resident #55 was admitted on 3/13/21 with a diagnosis of osteoarthritis, hypertension, and cerebral infarction. The admission Minimum Data Set dated 3/17/20	F 554	F554 On 5/4/2021 a resident self-administration of medications assessment was completed on resident #55. On 5/7/2021 Med Aide #1 was re educated by the Director of Nursing on the importance of not leaving medications at the bedside. On 5/4/2021 Director of Nursing completed a self administration of medications assessment on 100% of residents. On 4/14/2021 an in service was initiated by the Director of Nursing for the	5/11/21

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F 554	Continued From page 5 revealed she was cognitively intact. She required extensive assistance with bed mobility, transfers, and toilet use. She had upper extremity impairment on one side. A record review for Resident #55 revealed no self-administration medication assessment or physician order. On 4/12/21 at 8:30 am, Resident #55 was observed sitting up in bed with medications in a small cup on her over the bed table along with her breakfast tray. She was observed patting her chest with her hand and stated, "I think I dropped one." Med Aide #1 was not observed in the room. Resident #55 was observed placing the cup to her mouth when Med Aide #1 was observed re-entering the room. Resident #55 placed her cup with medications in it back on the over the bed table and told Med Aide #1 that she dropped one. Med Aide #1 checked Resident's #55's bed linens but did not find any medications. On 4/12/21 at 8:32 am, Med Aide #1 was interviewed. She stated Resident #55 was taking her medications when she left the room to go across the hall to answer a call bell. An interview was conducted with Nurse #1 on 4/16/21 at 9:15 am and she stated she waits for the resident to take their medications before she leaves the room. She also stated a self-administration assessment and a physician order was needed before a resident could take their medications without supervision. On 4/16/21 at 5:00 pm, an interview was conducted with the Administrator. She stated the med aide should have supervised the resident taking her medications.	F 554	nurses and medication aides on: It is never okay to leave medications at the residents bedside, unless a self-administration of medications assessment is completed for the resident. Even if a resident asks to leave medications; do not! It is important that all of the medication is taken prior to leaving the residents room. After a medication is given to a resident you should discard the medication cup prior to leaving the residents room. To be completed by 5/11/2021. Director of nursing and/or unit manager will complete observational audits during med pass to ensure med aides and nurses are not leaving medications at bedside. The audit findings will be documented on the Self Administration of medications Audit Tool. The Director of Nursing and/or unit manager will observe 3 med passes weekly X 4 weeks; 1 med pass weekly X 4 weeks; then monthly X 1 month. Administrator will review results of the Self Administration of Medications Audit Tool Director of Nursing or Administrator will complete a summary of the audit results and present to the QAPI committee for review and recommendations for any modifications of the monitoring process X 3 months.	
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3)	F 558		5/11/21

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F 558	Continued From page 6 §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on record review, observations and resident and staff interviews, the facility failed to ensure a dependent resident could access the call bell to request staff assistance for 2 of 26 residents observed for call bells. (Resident # 56, Resident #55) Findings included: (1) Resident #56 was admitted to the facility on 3/15/2021, and diagnoses included a Cerebral Vascular Accident (Stroke), COVID-19 and Pneumonia. The 5-day admission Minimum Data Set (MDS) dated 3/18/2021 revealed Resident #56 was moderately mentally impaired with an impairment to one side of the body and required extensive assistance for transfers. The care plan dated 3/15/2021 revealed Resident #56 was a risk for falls. Interventions included making sure Resident #56 ' s call light was within reach and encouraging Resident #56 to use the call bell for assistance as needed. The interventions further noted Resident #56 needed prompt response to all requests for assistance. On 4/12/2021 at 12:41pm, Resident #56 was observed sitting up in her wheelchair beyond the foot of the bed facing the head of the bed. The	F 558	F558 Call Bells On 4/16/2021 Director of Nursing completed an observation audit to ensure residents #55 and #56 call bell was within reach. On 4/16/2021 Director of Nursing and unit manager completed an observational audit to ensure current residents call bell were within reach to ensure facility provide reasonable accommodations for residents needs. On 4/16/2021 Director of Nursing initiated an in service to Nursing staff on: Call bells are to be placed within residents reach at all time. This ensure residents are safe and able to call for help when needed. This practice should be done prior to exiting residents room. If resident is in the bed, call bell should be within residents reach. Always pay to attention to residents ability to move. Meaning, if a resident is flaccid and/or unable to move a limb; place call bell on residents dominant side. The same concept for wheelchair; to ensure reasonable accommodations of residents needs. To be completed by 5/11/2021. On 4/16/2021, Director of Nursing and Administrator initiated a Call bell Audit Tool to ensure residents had reasonable	

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F 558	Continued From page 7 call bell was observed lying at the head of the bed out of Resident #56 ' s reach. On 4/14/2021 at 3:35pm, Resident #56 was observed sitting in a high back wheelchair beside the right side of her bed. She stated she pushed the call button to notify the staff when she needed something and reached with her right hand above the back of the wheelchair. The call bell was observed at the head of the bed attached to the pillow case and out of reach for Resident #56. Resident #56 stated, "I can use hers" referring to her roommate. When Resident #56 reached for the roommates call bell with her right hand, she was unable to reach the call bell. On 4/15/2021 at 2:00pm, Nurse #4 stated when Resident #56 was up in her wheelchair, the call bell was hooked to her clothing or the chair for easy access. She also stated if the wheelchair was beside the bed, the call bell would be laid on the bed so the resident could reach across with her right hand to use the call bell for assistance. On 4/16/2021 at 3:57pm in an interview with the Director of Nursing, he stated call bells should be within the reach of the resident. On 4/16/2021 at 4:32pm in an interview with the Administrator, she stated residents ' call bells were to be within reach of the resident. 2. Resident #55 was admitted to the facility on 3/13/21 with diagnosis of osteoarthritis, hypertension, and cerebral infarction. Resident #55's admission Minimum Data Set dated 3/17/20 revealed she was cognitively intact.	F 558	accommodations for their needs. Audits will be completed by the nurse manager/Director of Nursing/assigned Lead Certified Nurse Assistant Weekly X 8 weeks; then monthly X 1 month. Administrator will review results of the Call Bell Audit Tool. Director of Nursing or Administrator will complete a summary of the audit results and present to the QAPI committee for review and recommendations for any modifications of the monitoring process monthly X 3 months.	

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F 558	Continued From page 8 She required extensive assistance with bed mobility, transfers, and toilet use. She had upper extremity impairment on one side. On 4/12/21 at 8:25 AM Resident #55 was observed lying in bed with her call bell clipped to the top right side of a sheet under the resident. The call bell was observed lying at the resident's right elbow. She attempted to reach the call bell with her right hand and was unable to position her arm to reach it. She then tried to reach over with her left hand and was unable to reach far enough to touch the call bell. NA #1 was observed moving the call bell within reach of the resident. Resident #55 was interviewed on 4/12/21 at 8:26 AM and she stated she could not reach her call bell. NA #1 was interviewed on 4/12/21 at 8:27 AM while in Resident #55's room. She stated she had not provided care for Resident #55 and she also observed the resident's call bell was not in reach. She stated when she provides care to any resident, she places their call bell in reach before she leaves the room. The Administrator was interviewed on 4/16/21 at 5:00 PM and she stated call bells should always be left where the resident can reach it.	F 558		
F 584 SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to	F 584		5/11/21

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F 584	Continued From page 9 use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on record review, observations and resident, family and staff interviews, the facility failed to arrange the room furnishings to display personal items for 1 of 3 residents (Resident #14) residing in Room 28 and failed to repair an overbed table for 1 of 1 resident rooms reviewed. (Resident #7)	F 584	F584 Safe/Clean/Comfortable/Homelike environment On 4/15/2021, Maintenance Director and the Administrator checked room 28 to ensure resident #14 have a nightstand for the stationary bed side table and Overbed	

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F 584	Continued From page 10 Findings included: (1) Resident #14 was admitted 1/6/2021. The admission Minimum Data Set (MDS) dated 1/10/2021 revealed Resident #14 was severely mentally impaired, nonverbal and required total care for all activities of daily living. On 4/12/2021 at 9:50am, Room 28 was observed with room furnishings for three residents. Resident #14's living area was located in the middle of the three living areas between two privacy curtains. The living area was observed with the bed Resident #14 was lying in, an overbed table with no items on it and an oxygen concentrator on the floor on the right side at the head of the bed. There was approximately 12 inches of space observed between both sides of the bed and each privacy curtain. On 4/13/2021 at 3:29pm in a phone conversation with a family member, she stated Resident #14 did not have a night stand in his living area. She stated she did not send flowers or cards on his birthday on April 8, 2021 because there was nowhere to place the items. On 4/16/2021 at 9:45am in an interview with the Maintenance Director, he stated furnishing in a resident ' s room included overbed tables, night stand, cabinets, beds, lights, windows, bathroom and a television. On 4/16/2021 at 9:50am in an interview with the Regional Vice President of Clinical Support in Room 28, she stated Resident #14 had a night	F 584	Table for mobile table and ensure resident#7 Overbed table was repaired and stationary bedside table were placed in close proximity of the resident. On 4/16/2021, Maintenance Director initiated an audit to ensure current resident rooms had an overbed table that was not in need of repair and to ensure stationary bedside tables were in close proximity of residents. Any deficiencies noted was corrected immediately. On 4/16/2021, Administrator reeducated Maintenance Director on the importance of ensuring all rooms have an overbed tables that are not in need of repair. On 4/16/202, Director of Nursing and the Administrator initiated an in service for Nursing staff on: It is important to keep residents overbed tables and stationary bedside tables are in close proximity of the residents. If at any time an overbed table needs repair; it is important to put order in Tels and notify their supervisor and/or maintenance director. This is to ensure facility provides a safe, clean, comfortable, and homelike environment for our residents; to be completed by 5/11/2021. On 4/16/2021, Director of Nursing and Administrator initiated a Bedside Table Audit observation tool to ensure residents have a nightstand for the stationary bed side table and Overbed Table for mobile table. Audit will be completed by the Maintenance Director daily weekly X 8	

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F 584	Continued From page 11 stand in the room and pointed to the night stand observed to the right of the privacy curtain between two wall cabinets located at the foot of the bed in the living area for another resident residing in the room. On 4/16/2021 at 4:32pm, the Administrator stated the night stand was not at the bedside, but there was a night stand designated for Resident #14 in the room. (2) Resident #7 was admitted to the facility 3/1/2016. The Minimum Data Set (MDS) dated 11/21/20 revealed Resident #7 was cognitively intact, spoke clearly and was easily understood. The MDS further revealed Resident #7's independence with eating. The care plan dated 1/28/2021 revealed Resident #7 had ongoing activity participation and listed reading, spiritual activities and games as preferred activities. On 4/14/2021 at 2:35pm, Resident #7 stated his overbed table was still broken. The top of the overbed table was observed wobbling when touched, and Resident #7 was able to swirl the base of the overbed table 360 degrees. Resident #7 stated he had informed the staff. On 4/15/2021 at 10:08am in an interview with the Maintenance Director, he stated resident's equipment in the rooms was checked weekly for proper functioning. He was informed Resident #7 overbed table was loose and swirled around the base 360 degrees. He stated,	F 584	weeks; then monthly X 1 month. Administrator will review the results of the audit. Director of Nursing or Administrator will complete a summary of the audit results and present to the QAPI committee for review and recommendations for any modifications of the monitoring process X 3 months.	

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F 584	Continued From page 12 "I haven't checked it this week." On 04/16/2021 at 9:45am in an interview with the Maintenance Director, he stated he did not keep a record of residents ' rooms being checked weekly. He stated he was notified by the staff of equipment repairs through workorders in the computerized system. He stated he was not aware the overbed table needed repair and stated he did not maintain a log of completed work orders or tasks. On 4/16/2021 at 4:32pm in an interview with the Administrator, she stated non-working equipment was fixed immediately when the maintenance director or herself were notified by the residents or staff.	F 584		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff and resident interviews and record review, the facility inaccurately coded the use of insulin for a non-diabetic resident (Resident #29) and an invasive mechanical ventilator (Resident #46). Findings included: 1.A review of the medical record revealed Resident #29 was admitted 6/30/2020 with diagnoses including Acute Kidney Failure, Chronic Obstructive Pulmonary Disease,	F 641	F 641 Accuracy of Assessments On 4/13/21, the MDS nurse updated The Minimum Data Set (MDS) assessments for residents # 29 and on 4/14/21 for resident #46 to reflect accurate coding for Insulin and ventilators. On 4/14/21 director of nursing (DON), Nurse supervisor, and/or MDS nurse and hall nurse initiated an audit of current residents last completed MDS assessment for each resident to ensure the MDS assessment reflected accuracy	5/11/21

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F 641	Continued From page 13 Rhabdomyolysis, Transient Ischemic Attack and falls. A review of the Quarterly Minimum Data Set (MDS) dated 2/11/2021 indicated Resident #29 received insulin injections for seven days of the lookback period of Resident #29 ' s assessment for medications. A review of the diagnoses in the MDS did not include Diabetes Mellitus. Resident #29 was indicated to be cognitively intact. A review of the physician orders dated February 2021 revealed the resident did not have an order for insulin. In an interview on 4/13/2021 at 2:30 PM, Resident #29 stated he did not take insulin and did not have Diabetes. In an interview on 4/14/2021 at 1:25 PM, the MDS coordinator stated she was too busy, and she did not know how insulin got checked in the MDS. On 4/16/2021 at 3:34 PM, the facility Administrator stated all MDS assessments should be coded accurately. 2. A review of the medical record revealed Resident #46 was admitted on 12/23/2020 with diagnoses of Alzheimer ' s disease, Dementia, Chronic Obstructive Pulmonary Disease and Hypertension. A review of the Quarterly Minimum Data Set (MDS) dated 3/05/2021 indicated Resident #46 was coded as being on an Invasive Mechanical Ventilator (ventilator or respirator) while a resident in the facility for seven days of the lookback period. A review of the diagnoses in the MDS did not include mechanical ventilation. Resident #46 had mild cognitive impairment.	F 641	to include accurate coding for ventilators and residents receiving insulin. This audit will be completed on 5/11/2021. Any identified areas of concern were modified by the MDS nurse as indicated by the RAI Manual. On 5/3/2021, the Administrator re educated the MDS nurses on MDS Accuracy to include the following: MDS assessments must contain accurate information of resident assessment including residents receiving insulin and Ventilators. 1.MDS coordinator will use RAI process and the scope of RAI impact which includes Quality Measures, Five Star rating, reimbursement, and survey outcomes. The MDS nurse will use RAI user's manual and understanding the MDS item sets to code accurately. It is never ok to code inaccurately; as all care plans must accurately reflect the resident to ensure person centered plans are being utilized specific to the resident. All future MDS coordinators will receive this re-education during their orientation process. Beginning 5/5/21 the Director of Nursing, and/or registered nurse (RN) supervisor will utilize a MDS Accuracy audit tool to monitor the accuracy of future completed MDS assessments for coding of Insulins and ventilators. The MDS Accuracy Audit tool will be completed for 25% of completed MDS assessments weekly x 4 weeks, then bi-weekly x 4 weeks then 10% monthly x 1 months. All identified areas of concern will be addressed immediately by the MDS Nurse, DON, and/or RN supervisor for modification or	

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F 641	Continued From page 14 In an interview on 4/14/2021 at 10:12 AM, Resident #46 stated she had never been on a mechanical ventilator while a resident at the facility. In an interview on 4/14/2021 at 2:44 PM, the MDS coordinator stated she coded invasive mechanical ventilation in error and had been so busy that she was sure she had missed a few things. An interview with the Administrator on 04/16/2021 at 3:34 PM revealed all MDS assessments should be coded accurately.	F 641	significant correction of the MDS assessment by the MDS nurse to accurately reflect the resident's current condition. Administrator will review results of the MDS Accuracy Audit Tool. The Director of Nursing and/or Administrator will present all findings at the monthly QI committee meeting x 3 months for review and recommendations for any modification of monitoring process and to discuss the quality improvement process and/or any recommendations for sustaining compliance and continued monitoring.	
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 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	F 644		5/11/21

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F 644	Continued From page 15 by: Based on staff interviews and record review, the facility failed to apply for a Pre-Admission Screening and Resident Review (PASARR) Level II for 1 of 1 residents reviewed for PASARR level II (Resident #15), when there were diagnoses that qualified for a screening after admission. Findings included: Resident #15 was admitted to the facility on 3/29/19 with a Level I Pre-Admission Screening and Resident Review (PASRR). Record review revealed Resident #15 was given a diagnosis of Schizophrenia on 7/2/19. There was no documented evidence a Level II PASRR screening had been completed after 7/2/19. The resident ' s annual Minimum Data Set (MDS) dated 1/28/20 revealed she was cognitively intact, and she had a diagnosis of Schizophrenia and no PASRR Level II was indicated. On 4/14/21 at 2:16 PM an interview was conducted with the Social Worker. He stated he was responsible for applying for a PASRR Level II screenings for residents with a mental disorder on admission. He stated he didn ' t understand why he needed to apply for a PASRR Level II for Resident #15. It was explained to him Resident #15 did not have a diagnosis of Schizophrenia on admission. She was diagnosed during her stay and a PASRR Level II screening would still be needed for the resident. The Administrator was interviewed on 4/16/21 at 5:00 PM and she stated a PASRR Level II should have been applied for if the resident had a diagnosis of a mental illness.	F 644	F 644 PASARR On 5/5/2021 Social Worker checked the National PASSAR system to ensure resident #15 had a PASARR level 2. Current residents audited for PASARR numbers completed 5/06/2021 by the facility Social Worker. The MDS assessments for residents identified with a level II PASARR were audited by the MDS Nurse on 5/06/2021. No MDS assessments need modification due to PASARR level 2. On 5/6/2021The facility Administrator in-serviced the Social Worker, MDS Coordinator, and Director of Nursing related to ensuring that all residents admitted into the facility must have a PASARR level 1 or 2. If any resident have a mental disorder and or a PASARR level 1 due to a significant change a PASARR must be submitted for Level 2 screening for the resident; to be completed by 5/11/2021. On 5/06/2021 the Social Worker and/or MDS Nurse began monitoring PASARR numbers and mental Diagnosis of admissions to ensure PASARR numbers are correct in the resident electronic	

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F 644	Continued From page 16	F 644	record and to ensure the MDS nurse is aware of the PASARR number using the PASARR number audit tool. The PASARR number audit will be completed weekly x 8 weeks; then monthly x 1 months. Administrator will review results of the PASARR Number Audit Tool. The monthly QI committee will review the results of the PASARR number audit tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.	
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	F 656		5/11/21

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F 656	Continued From page 17 physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document 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 staff interview and record review, the facility failed to develop a comprehensive care plan for one of seven residents reviewed for Activities of Daily Living (ADL) care (Resident #34). Findings included: A review of the medical record revealed Resident #34 was admitted 2/22/2021 with diagnoses	F 656	F656 Develop Comprehensive Care Plans ADL Care Plan was developed for Resident # 34 on 4/14/2021 by the MDS nurse An audit was completed by MDS Nurse on 4/14/2021 for residents to ensure ADL's were a part of the residents person centered comprehensive care plan. The MDS nurses were in-serviced by the	

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F 656	Continued From page 18 including Acute Kidney Failure and pressure ulcer. The Admission Minimum Data Set (MDS) dated 2/25/2021 indicated Resident #34 was cognitively intact, could eat independently with tray set up and needed total assistance for toilet use and bath with the help of one person. The Care Area Assessment indicated a focus need of ADL care and would be addressed in the care plan. A review of Resident #34 ' s care plan was noted to have no plan for ADL care. On 4/16/2021 at 6:00 PM, the MDS coordinator was interviewed and stated she did not understand why the lack of an ADL care plan did not trigger in the electronic health record system, and she would create an ADL care plan. On 4/16/2021 at 6:15 PM the facility Administrator stated the care plan should be comprehensive for ADL care.	F 656	Administrator on 5/3/2021 to ensure that all residents have a person centered comprehensive care plan to include ADL's. The MDS or Director of Nursing will complete a 10% sample audit of the Care Plans for ADL's to ensure there is a comprehensive Care Plan bi-monthly for three months. The Director of Nursing and/or Administrator will present all findings at the monthly QI committee meeting x 3 months for review and recommendations for any modification of monitoring process and to discuss the quality improvement process and/or any recommendations for sustaining compliance and continued monitoring.	
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.	F 657		5/11/21

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F 657	Continued From page 19 (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 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 resident and staff interviews and record review, the facility failed to conduct a care plan meeting and invite the resident to the care plan meeting for 2 of 26 residents reviewed for care plans (Resident #18 and Resident #19). 1. Resident #18 was admitted on 8/17/19. Her diagnosis included Cerebral Vascular Accident, Diabetes Mellitus, and Hypertension. The quarterly Minimum Data Set dated 3/26/21 revealed Resident #18 was cognitively intact. Record review revealed her last care plan was updated on 3/25/21. On 4/12/21 at 12:23 PM an interview was conducted with Resident #18. She stated she had not been invited or attended a care plan meeting. An interview was conducted with the Social Worker on 4/15/21 at 11:36 AM and he stated that a care plan meeting had not been conducted since 10/8/20. He stated care plan meetings had not been held and an invitation had not been sent.	F 657	F657 Care Plan Timing and Revision On 5/7/2021 resident #18 and resident #19 was given a care plan invitation by the Social Worker On 5/4/2021 All current residents were audited by MDS Nurse for upcoming quarterly care plan meetings. Residents due for a comprehensive care plan meeting were sent care plan invitations. On 5/7/2021 Administrator initiated an in service on the importance of ensuring all residents receive care plan invitations for comprehensive care plan meetings. To be completed by 5/11/2021 On 5/7/2021 Administrator and Director of Nursing initiated a Care Plan Audit Tool to ensure all residents receive care plan invitations prior to the scheduled care plan meetings. MDS Nurse/Social Worker	

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F 657	Continued From page 20 On 4/15/21 at 11:35 AM an interview was conducted with the Administrator and she stated care plan meetings should be held quarterly and the resident or the responsible party should be invited to attend. 2. Resident #19 was admitted on 10/10/20. His diagnosis included Acute Kidney Failure, Osteomyelitis, and Adult Failure to Thrive. The quarterly Minimum Data Set dated 1/23/21 revealed Resident #19 was cognitively intact. Record review revealed his last care plan meeting was held on 10/12/20. His care plans were updated on 10/30/20 and 1/21/21. An interview with Resident #19 on 4/13/21 at 10:19 AM was conducted and he stated he had not been to a care plan meeting nor was he invited to attend a care plan meeting. An interview with the Social Worker was held on 4/14/21 at 2:16 PM. He stated a quarterly care plan meeting was not held with the resident and an invitation was not sent. On 4/15/21 at 11:35 AM an interview was conducted with the Administrator and she stated care plan meetings should be held quarterly and the resident or the responsible party should be invited to attend.	F 657	and/or Director of Nursing will complete Care Plan Audits utilizing the care plan Audit Tool Weekly X 8 weeks; then monthly X 1 month. Administrator will review results of the Care Plan Audits. Director of Nursing or Administrator will complete a summary of the audit results and present to the QAPI committee for review and recommendations for any modifications of the monitoring process X 3 months.	
F 677 SS=G	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview and record review, the facility failed to provide nail care for one resident (Resident # 37)	F 677	F 677 ADL care for Dependent Residents	5/11/21

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F 677	Continued From page 21 and toileting assistance for two residents (Resident #34 and Resident #5), for 3 of 23 residents reviewed for Activities of Daily Living (ADLs)which resulted in residents having incontinent episodes and one resident was "pi .... off" and one resident "did not like it." Findings included: 1.A review of the medical record revealed Resident #5 was admitted 12/30/2020 with diagnoses including Lumbar discitis, intraspinal abscess and obstructive uropathy. The Admission Minimum Data Set (MDS) dated 1/3/2021 indicated Resident # 5 was cognitively intact and needed extensive assistance for activities of daily living (ADL) care with the help of one person. The MDS noted Resident #5 was frequently incontinent for bowel and bladder and used a bedpan. In an interview on 4/14/2021 at 11:12 PM, NA #4 stated she did not think the facility had enough staff for her to address all her resident ' s needs. NA #4 indicated there were three residents she was not able to provide morning care for, including incontinent care on the morning of 4/14/2021, because she did not have help. In an interview on 4/16/2021 at 4:45 PM, Resident #5 stated a week before, he turned on his call bell at 9:00 PM because he needed to use the bedpan. Resident #5 stated an NA came into his room and turned the call bell off and said she would be back. The Resident stated he told her he needed to use the bedpan. Resident #5 noted an NA came in at 11:05 PM to help him get onto the bed pan. Resident #5 said it made him feel "pi	F 677	What measures did the facility put in place for the resident affected: On 4/16/2021 resident # 37 was provided assistance with shaving, nail care, and dressing by the certified nursing assistant (CNA). On 4/16/2021 Resident #34 and Resident #5 was off toileting assistance by Certified Nurse Assistant What measures were put in place for residents having the potential to be affected: On 4/16/2021 current residents were audited to ensure they had received assistance with, shaving, nail care, toileting, and being appropriately dressed by Director of Nursing and/or Unit manager. Any areas of concern were immediately addressed. To be completed 5/11/2021 What systems were put in place to prevent the deficient practice from reoccurring: On 4/16/2021 an in-service was initiated by the Director of Nursing for current nursing staff related activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene to include nail care, dressing, and shaving. The in-service will be complete by 5/11/2021. All newly hired employees will receive the in-service during new employee orientation.	

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(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 677	Continued From page 22 .... off" and he reported it to the nurse. 2.The medical record revealed Resident #34 was admitted 2/22/2021 with diagnoses including Acute Kidney failure, and sacral pressure ulcer. The Admission Minimum Data Set dated 2/25/2021 assessed Resident #34 as cognitively intact and needed total assistance for the activities of daily living (ADLs) of bath and toilet use with the help of one person. The Care Area Assessment noted a focus of ADL care and indicated a care plan would be initiated. There was no care plan for ADLs. On 4/16/2021 at 4:10 PM, Resident #34 was interviewed and stated he often waited 30 minutes for assistance to the bedpan and had waited 50 minutes. Resident #34 stated he could not always wait and would have an accident, he stated "I don ' t like it, but I still have to wait." Resident #34 indicated the longer wait was mostly at night. 3. A review of the medical record revealed Resident #37 was admitted 7/28/2020 with diagnoses including Stroke, Hemiplegia, Hemiparesis, Major Depressive Disorder and Gastrostomy (tube inserted into the stomach for nutrition.) The Annual Minimum Data Set (MDS) dated 1/13/2021 noted Resident #37 to be moderately impaired for cognition and needed extensive to total assistance for all ADL care with the help of one person. The MDS noted no rejection of care. The Care Area Assessment indicated a focus of ADL care and this area went to care plan.	F 677	How the facility will monitor systems put in place: On 4/16/2021 resident nail care, shaving, and dressing began being audited by Director of Nursing/MDS Nurse/ and/or Unit manager to ensure residents are receiving assistance with nail care, shaving, and dressing, and toileting using the ADL audit tool. The ADL audit tool will be completed for 5 residents weekly x 8 weeks , then 5 residents monthly x 1months. The Executive Quality Improvement Committee will review the results of the audits Monthly x 4 months with recommendation and follow up as needed or appropriate for continued compliance in this area and to determine the need for and or/ frequency of continued QI monitoring	

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The care plan dated 7/23/2019 indicated Resident #37 had a self-care deficit for ADLs related to past Stroke and Hemiparesis. Interventions included honor the resident ' s preference for bathing/showering. The resident is dependent on staff for personal hygiene and oral care.

On 4/12/2021 at 9:30 AM, Resident #37 was observed lying in bed with clean fingernails extending approximately ¼ inch longer than his fingertip. Resident #37 did not speak clearly but could shake his head for yes and no and could shape words with his mouth. When asked if he liked his fingernails long Resident #37 shook his head to indicate no. When asked if he would like his fingernails trimmed, the Resident nodded his head to indicate yes.

On 4/13/2021 at 10:00 AM, Resident #37 was observed in bed asleep and his fingernails appeared to be the same length as the day before. Resident #37 was observed with the same long nails on the afternoon of 4/13 and the morning of 4/14/2021.

On 4/13/2021 at 1:30 PM, NA #10 stated he shaved residents and trimmed nails when there was enough staff. NA #10 stated if someone calls out the tasks change from extra care to what is necessary. NA #10 also noted that he may not have the same assignment two days in a row, so a resident that he did not get to shave on his assignment one day, may not be on his assignment the next day, or even the following day, and some residents don ' t want female NAs to do shaving or nail care.

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F 677	Continued From page 24 In an interview on 4/14/2021 at 2:30 PM, Nursing Assistant (NA) #2 stated she had Resident #37 on her assignment that day and she had given him a bath but did not trim his nails. Upon being told that Resident #37 had indicated on 4/12/2021 that he wanted his nails trimmed, NA #2 stated she did not have Resident #37 on her assignment on 4/12/2021. The Director of Nursing (DON), upon seeing Resident #37 ' s nails on 4/14/2021 at 2:35 PM, stated nail care was part of ADL care and Resident #37 ' s nails would be trimmed. On 4/15/2021 at 9:10 AM, NA #7 indicated that nail care was part of ADL care. In an interview on 4/15/2021 at 9:55 AM, NA #1 stated hair care, oral and nail care were part of ADL care. NA #1 stated she had trouble completing her work when there was not enough staff. On 4/15/2021, the Director of Nursing stated he knew there was a lot of work to do and he expected good care to be given to all residents.	F 677		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary	F 690		5/13/21

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F 690	Continued From page 25 incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to cleanse and secure the urinary catheter for 1 of 4 residents reviewed for indwelling catheters. (Resident #54) Findings included: Resident #54 as admitted on 3/12/2021 to the facility. Diagnoses included end stage renal disease, neurogenic bladder, obstructive uropathy and Diabetes Mellitus.	F 690	F690 Bowel and Bladder On 4/15/2021, resident #54 Catheter was cleansed properly by the Director of Nursing and Unit Manager. On 4/15/2021, a leg strap was given to secure resident Foley Catheter. On 4/16/2021, current residents with catheters were audited to ensure leg straps were in place. On 4/16/2021, Director of Nursing and Unit manager	

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F 690	Continued From page 26 The admission Minimum Data Set (MDS) dated 3/16/2021 revealed Resident #54 was cognitively intact and had an indwelling catheter. The care plan dated 4/1/2021 for Resident #54 revealed a focus on an indwelling catheter, and interventions included securing with a catheter leg strap at all times. Physician orders dated 4/12/2021 revealed orders for a catheter leg strap on at all times and to cleanse the urinary catheter with soap and water every shift. On 4/15/2021 at 10:21am, Resident #54 was observed with no leg securing device to the urinary catheter when he turned on his right side with the urinary catheter bag to the left side of the bed. On 4/15/2021 at 10:28am, Resident #54 ' s suprapubic indwelling urinary catheter was observed with a dry crusted dark material around the urinary catheter near the insertion site. On 4/15/2021 at 10:29am after completing wound care, Nurse #4 asked Resident #54 where his leg strap was and stated she would get him a leg strap. On 4/15/2021 at 10:41am in an interview, Nurse #4 stated nurses applied the leg strap to secure the urinary catheter. She further stated Resident #54 should have had a leg strap on, so the catheter was not pulled. Nurse #4 further stated nurse aides and nurses were responsible for cleaning the urinary catheter daily. On 4/15/2021 at 11:05am, Nurse Aide(NA) #3	F 690	observed catheter care being performed on residents correctly per facility guidelines. On 4/16/2021, an in-service was initiated by the Director of Nursing for Current nursing staff on how to properly cleanse a catheter and the importance of securing a catheter; to be completed by 5/13/2021. On 4/16/2021, Administrator and Director of Nursing initiated a Bowel and Bladder Audit Tool to ensure all residents are receiving proper catheter care and have a leg on strap per facilities guidelines. Director of Nursing/unit manager and/or treatment nurse will observe 6 residents weekly X 8 weeks; monthly X 1 month. Administrator will review results of the Care Plan Audits. The Director of Nursing and/or Administrator will present all findings at the monthly QI committee meeting x 3 months for review and recommendations for any modification of monitoring process and to discuss the quality improvement process and/or any recommendations for sustaining compliance and continued monitoring.	

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stated he had completed Resident #54's bath and was observed applying Resident #54 ' s pants while he was standing and holding onto the walker. Resident #54 ' s suprapubic indwelling urinary catheter was observed with dry crusted dark material on the tubing near the insertion site in the lower abdomen. When NA #3 was asked if he washed the catheter, he stated he washed the skin around the catheter, but not the urinary catheter. In cleaning the urinary catheter with soap and water, NA #3 washed the urinary catheter using strokes upward toward the insertion site. The dark brownish black ring remained on the urinary catheter. NA #3 used a disposable wipe to remove the remaining material from the urinary catheter.

On 4/15/2021 at 11:08am in an interview with NA #3, he stated the urinary catheter was washed daily, and he was to clean away from the insertion site to prevent infection.

On 4/16/2021 at 4:13pm in an interview with the Director of Nursing, he stated urinary catheters were to be washed with soap and water every shift and secured with a leg strap when residents were out of bed.

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F 690	Continued From page 28	F 690		

Actions

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F 690	Continued From page 29 Indwelling Urinary Catheter Care: cleanse with soap and water every shift every shift Other Discontinued 4/12/2021 15:00 4/15/2021 4/12/2021	F 690		

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F 690	Continued From page 30	F 690		

Actions
Record foley output QS. Alert MD if diminished output noted

MAR
04/16/21 04:13 PM DON. CC q shift, Soap and water and towel, keep the bag attach to side of the bag below, leg strap when up and nurse assess catheter every shift. Fig leaf or bag to cover for diginty.

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	F 692		5/13/21

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F 692	Continued From page 31 comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to provide staff assistance with meals and implement the physician ' s request for an appetite stimulant for 1 of 3 residents reviewed for nutrition needs. (Resident #56) Findings included: Resident #56 was admitted was admitted to the facility on 3/15/2021, and diagnoses included a cerebral vascular accident (stroke). The 5-day admission Minimum Data Set (MDS) dated 3/8/2021 revealed Resident #56 was moderately cognitively impaired, had upper mobility impairment to one side of the body and required extensive assistance of one person for eating. The MDS further revealed she was on a mechanical altered diet that required puree foods and thickened liquids.	F 692	F 692 Nutritional Hydration Maintenance On 4/15/202, Director of Nursing notified Medical Director and started Remeron per Dietary recommendation. An audit was initiated by the Director of Nursing on 5/12/2021, for current residents who are at risk for weight loss to ensure dietary recommendations by facility Medical Director were implemented. The Director of Nursing was in-serviced by the Administrator 5/12/2021, related to the importance of ensuring all dietary recommendations are implemented; to include feeding residents during meal times if needed. To be completed by 5/13/2021. The Director of Nursing initiated an in service for current nursing staff on the importance of	

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F 692	Continued From page 32 A review of the physician ' s orders dated 3/23/2021 revealed Zofran, a medication for nausea and vomiting, and a frozen nutritional treat once a day was ordered for Resident #56. The care plan dated 3/29/2021 revealed Resident #56 was a nutritional risk due to the mechanical altered diet, thickened liquids and inadequate oral intake. The nutritional goal was for Resident #56 to consume 75% from two of the three meals served daily. Interventions included providing and serving the diet as ordered, monitoring, documenting, and reporting as needed any signs or symptoms of dysphagia and refusals to eat, providing nutritional interventions as ordered and monitoring intake and output every meal. Resident #56 ' s care plan dated 4/6/2021 also focused on her activities of daily living self-care performance deficit and interventions included Resident #56 requiring limited assistance of one staff member to eat. On 3/29/2021, the dietary notes revealed Resident #56 was dependent with meals, consumed less than 50% for most meals, refused two meals and complained of nausea. The Dietitian recorded Resident #56 was receiving fortified food with meals and a frozen nutritional supplement for nutrition and documented she was consuming 0-50% of the supplement. Therefore, the dietician recommended a physician consult to review Resident #56 for an appetite stimulant due to inappropriate intake and poor acceptance of the supplement. On 3/30/2021, an Administrator ' s note revealed during the risk meeting the physician	F 692	assistant residents during meal times. To be completed by 5/13/2021. The Director of Nursing will begin Feeding Assistance Observation Tool Audits for residents that require feeding assistance to ensure residents are receiving proper nutrition utilizing the Feeding Assistant Observation Audit tool. Director of Nursing/unit manager will observe 5 resident meals weekly X 8 weeks then monthly X 1 month. Director of Nursing will Audit Dietary recommendations utilizing the Dietary Recommendation Audit Tool. Weekly X 4 weeks, Bi weekly X 4 weeks; then monthly X 1 month. Administrator will review results of the audits. The monthly QI committee will review the results of the Meal Tray Audit Tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.	

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recommended to start Remeron, an appetite stimulant, 7.5 milligrams(mg) daily for one week followed by Remeron 15mg daily.

A review of the nursing notes revealed Resident #56 had a poor appetite, consumption of meals decreased from 50% to less than 25% and she had a tendency not to feed herself and needed encouragement.

On 4/12/2021 at 12:50pm, Resident #56 was observed sitting with an untouched meal tray in front of her. She used her right hand to pick up the cup of tea to drink. She made no attempts to pick up utensils to eat the food. She stated, "I don ' t like it." Nurse Aide (NA) #7 entered the room and removed the meal tray without offering her anything else to eat or offering to assist her with the meal.

On 4/15/2021 at 8:18am, Resident #56 was observed sitting up in the bed with a meal tray positioned in front of her. NA #8 entered the room with a straw for Resident #56 and stated to her, "I want you to eat this morning now," before exiting the room. Resident #56 was observed using her right hand to drink her orange juice through the straw and picking up the fork and spoon. When she used the fork to pick up a small amount of food to the tip of the fork, she laid the fork down on the plate instead of moving the fork to the mouth. She used the spoon to take only one bit each of the grits and oatmeal. She continued to pick up the empty glass of orange juice to drink. Resident #56 placed the plate cover over the plate. No staff member entered to assist her with the meal.

On 4/15/2021 Resident #56 weighed 166.6

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pounds. There was a 1.5 pound weight loss since admission.

On 4/15/2021 at 8:56am, NA #8 entered the room to remove the roommate ' s meal tray, and the Business Office Manager entered to remove Resident ' s #56 meal tray. Resident #56 was asked if she was finished and how breakfast was by the Business Office Manager and answered, "Alright." The plate cover was not raised to assess the intake of the meal.

On 4/15/2021 at 9:02am, NA #8 stated Resident #56 could feed herself, but staff had to check on her, encourage her to eat and offer to feed her. She stated Resident #56 would allow staff to feed her. When asked why no staff entered during the breakfast meal to assist Resident #56, NA #8 stated she gave her a mouthful when she set the meal tray up to get her started, "She ' s not at feeder."

On 4/15/2021 at 9:12am, Nurse #4 stated Resident #56 was able to feed herself, but staff needed to encourage and assist her during the meal.

On 4/15/2021 at 11:40am in a phone interview with the Dietitian, she stated based on the documentation of nurse aide tasks and nurse ' s notes Resident #56 needed help with feeding and meals. She further stated Resident #56 was receiving fortified foods and the frozen nutritional supplement, but her oral intake was poor. She stated there were limited options for other supplements due to Resident #56 receiving thickened liquids. Therefore, she recommended an appetite stimulant to the physician.

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On 4/15/2021 at 4:20pm, NA #9 stated Resident #56 required staff to stay and encourage her during meals by placing the spoon in her hand to take food to the mouth and sometimes fed her. She further stated Resident #56 could tell the staff when she had eaten all she wanted.

On 4/15/2021 at 11:56am, a review of the physician orders revealed no order for Remeron, the appetite stimulant.

On 4/15/2021 at 1:55pm, a review of Resident #56 ' s medication administration record revealed no order for Remeron to be administered.

On 4/15/2021 at 2:00pm, Nurse #4 stated in an interview Resident #56 was not receiving an appetite stimulant medication and was unable to locate an order for the medication on the chart.

On 4/15/2021 in an interview with the Administrator, she stated the physician attended the risk meetings virtually, and she wrote the risk note on the chart. She stated the Director of Nursing or the assigned nurse would have entered the order.

On 4/16/2021 at 3:59pm in an interview with the Director of Nursing, he stated residents were to be assisted with meals to endure adequate nutrition was provided when allowed. He further stated Resident #56 could feed herself, but if staff picked up an untouched meal tray without encouraging or assisting her, that was an issue to be addressed.

On 4/16/2021 at 4:32pm in an interview with the Administrator, she stated the recommendation for the appetite stimulant was communicated during

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F 692	Continued From page 36 the risk meeting but was not delegated out from her notes.	F 692		
F 725 SS=G	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews and record review, the facility failed to maintain sufficient staffing resulting in nail care not being provided (Resident #37), and toileting	F 725	F 725 Sufficient Nursing Staff On 4/16/2021, the Administrator (Adm) and the Director of Nursing (DON) reviewed the staffing schedule to ensure	5/11/21

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F 725	Continued From page 37 assistance was not provided (Resident #34 and Resident #5) resulting in residents having incontinent episodes and one resident was "pi.... off" and one resident "did not like it." Findings included: This tag is cross referenced to F677. Based on observation, staff and resident interview and record review, the facility failed to provide nail care for one resident (Resident # 37) and toileting assistance for two residents (Resident #34 and Resident #5) for residents reviewed for Activities of Daily Living (ADLs),resulting in residents having incontinent episodes and one resident was "pi .... off" and one resident "did not like it." In an interview on 4/16/2021 at 7:52 AM, NA #6 stated even though her name was on the schedule for 4/13/2021 for the 11PM to 7AM shift, she did not work. NA #6 stated she was off that night. NA #6 stated the facility was often short of staff and even though she usually managed to get her work done, it was difficult. The facility Scheduler was interviewed on 4/16/2021 at 10:32 AM and stated there was not enough staff and she schedules regular staff as much as possible and then uses agency staff. The Scheduler stated the weekends were a problem because staff called out and she had to scramble to find someone to work. When asked specifically about 4/14/2021 on the 11PM to 7AM shift, the Scheduler stated there were only two NAs for the entire facility of 63 residents. On 4/16/2021 at 3:05 PM, NA #8 was interviewed and stated there was not enough staff. NA #8 indicated she would stay late, if she had to, to get	F 725	sufficient numbers of staff to provide nursing care to all residents in accordance with resident care plans. On 4/19/2021, the Adm and the DON reviewed the current schedule of staffing to ensure a sufficient number of staff to provide nursing care to all residents in accordance with resident care plans in the next week. On 4/20/2021, the Administrator met with/notified the Regional Director of Operations (RDO) of Accordius Health, staffing needs to provide nursing care to all residents in accordance with resident care plans. The RDO instructed the Adm to contact a sister facility and contract agency with current staffing needs. On 4/22/2021, the Administrator In serviced the DON regarding Sufficient Staff. The Sufficient Staff in-service included the following: A. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans. B. The determination of sufficient staff will be made based on the staff's ability to provide needed care to residents that enable them to reach their highest practicable physical, mental and psychosocial well-being. On 4/22/2021, the Adm and/or the DON initiated a QI monitoring tool titled Sufficient Staff tool to monitor for sufficient staff will be made based on the staff's ability to provide needed care to residents that enable them to reach their highest practicable physical, mental, and psychosocial well-being. The Adm and/or	

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F 725	Continued From page 38 her work done. In an interview on 4/15/2021, the Director of Nursing (DON) stated he had been hired in March. The DON stated he knew there was a lot to work on and he was trying his best to find staff. The DON stated it would be good to not depend on agency nurses, and his expectation was that good care be given to all residents.	F 725	the DON will utilize the Sufficient Staff tool five times weekly to include nights and weekends for four weeks, once weekly for four weeks, and monthly times one months. Any identified issues will be addressed immediately. The Adm and/or the DON will present findings from the Sufficient Staff tool at the monthly QI committee meetings for six months for further recommendations. The Adm will monitor the Sufficient Staff tool to ensure proper completion of the Sufficient Staff tool. The administrator will present findings at the quarterly Executive QI Committee meeting for further recommendations for follow up as needed or continued compliance in this area and to determine the need for and/or frequency of the continued QI monitoring	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 761		5/11/21

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F 761	Continued From page 39 §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to date five opened medications for 1 of 2 medication carts used for medication administration on A hall. Findings Included: On 04/15/2021 at 2:05 PM, observation of the medication administration cart known as "A-Front" with Nurse #4 revealed the following medications were open and without an open date: two Amelog Flex Pens (insulin for Diabetes), 100 units/mL (units per milliliter, 3mL for Resident #16 and Resident #17; one Novolog Flex Pen (insulin for Diabetes) 100 units/mL (units per milliliter), 3mL for Resident #11; one Lantus Pen (insulin for Diabetes) 100units/mL (units per milliliter) 3mL for Resident #11; and one Tresuba Pen (insulin for Diabetes) 100units/mL (units per milliliter) 3mL for Resident #30. An interview with Nurse #4 on 04/15/2021 at 2:11 PM revealed there should be an open date on all opened insulin pens because they expire 28 days after opening. She further stated an insulin pen without an open date should be thrown away. An interview with the Unit Manager on 4/15/2021	F 761	F761 storage and labeling of biohazards The five insulin pens that were not appropriately labeled and dated were discarded by the Med Nurse on 4/15/2021. An audit was completed on 4/16/2021 by the Director of Nursing to ensure all medications to include insulin are properly stored and labeled. Any identified areas of concern were immediately corrected by the Director of Nursing. An in-service was initiated with current license nurses to include nurse #4 regarding the dating of and expiration of multi-dose insulin pens by the Director of Nursing. The in-service will be completed by 5/11/2021. All newly hired license nurses will be in-serviced regarding dating of and expiration of multi-dose insulin pens during new employee orientation. The Director of Nursing/Assistant Director of Nursing/Unit manager, Unit Manager, or the RN supervisor will check all medication carts and medication rooms	

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F 761	Continued From page 40 at 3:48 PM revealed all medications, including insulin pens, should be dated at the time the seal is broken and should be discarded if opened and there is not an open date written on the medication. An interview with the Director of Nursing (DON) on 4/15/2021 at 4:15 PM revealed insulin pens are to be dated by the opening staff member when the seal is broken. He stated he would call the facility ' s supplier to find out when the last shipment was made to the facility. An interview with the Administrator on 04/16/2021 at 3:47 PM revealed all opened medications must be dated at the time it is opened or the seal is broken. She also stated she would call the facility ' s pharmacy supplier and ask when the medication was shipped to the facility.	F 761	weekly x 4 weeks then biweekly 4 weeks, then monthly x 1 months to ensure all multi-dose vials to include heparin and insulin are properly dated and not expired using the multi-dose vial audit tool All identified areas of concern will be immediately corrected. The monthly QI committee will review the results of the multi-dose vial audit tool monthly for 6 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight	
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	F 812		5/11/21

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F 812	Continued From page 41 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 observation and staff interview, the facility failed to remove expired items from one of one nourishment refrigerator. Findings included: On 4/15/2021 at 4:00 PM the nourishment refrigerator for the entire facility was inspected. There were two milk cartons dated 3/4/21, one milk carton dated 3/18/21, one milk carton dated 3/11/21, one milk carton dated 2/17/21 and one milk carton dated 2/28/21. One 8-ounce carton of sour cream dated September 2020; one individual container of peaches dated Dec. 17, 2020; one chocolate nutritional drink dated 7/1/2020; five cartons liquid meal replacement dated 1 Feb 2021;, six cartons nutrition shakes for residents on dialysis dated 1 Sep 2020 (2), 1 April 2021 (1), 1 Jan 2021 (3); three bottles high protein nutrition drink dated 1 Nov 2020; one large bottle hazelnut coffee creamer dated 1/6/21; nine individual containers of sugar free gelatin dated Sep 2020; four snack replacement shakes dated Sep 22 2020. There was a drink of some kind that had been spilled in the refrigerator and was wrapped in a bag. On 4/15/2021 at 4:40 PM in an interview, the Dietary Manager stated the nourishment refrigerator was the responsibility of nursing. On 4/16/2021 at 6:30 PM the Administrator stated nursing was responsible for the nourishment	F 812	F 812 Food Procurement, Store/Prepare/Serve-Sanitary On 4/16/2021, the Supply Manager disposed of the expired milk, sour cream, container of peaches, a chocolate drink, five cartons of liquid meal replacement, six cartons of nutrition shakes, three bottles of high protein drink, one bottle of hazelnut coffee creamer, and nine containers of sugar free shakes in a trash receptacle were removed from the bag on bins and changed, and the refrigerator was wiped down and cleaned thoroughly. On 4/16/2021, the Supply Manager completed an audit of current residents foods to ensure no expired foods were in any nourishment refrigerator to include milk and nutritional drinks. Any negative findings were immediately corrected. On 4/19/2021, the Director of Nursing in-serviced current Nursing Staff on Sanitary Conditions and monitoring of the nourishment refrigerators. The in-service included A. Foods must be stored labeled with resident name and date. B. Expired food must be discarded immediately to include nutritional drinks and milk. To be completed by 5/11/2021 On 4/19/2021, the Administrator initiated an audit tool titled labeling and dating Audit Tool to monitor all nourishment refrigerators Director of Nursing/unit	

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F 812	Continued From page 42 refrigerator.	F 812	manager and/or Assigned Nurse will complete audit twice weekly X 8 weeks, then monthly times 1 months. Any negative findings will be corrected immediately. Administrator will review results from the audits. The Director of Nursing and/or the Unit Manager will present findings from the Audit Tools at the monthly QI committee meetings for six months for further recommendations	
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;	F 880		5/11/21

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F 880	Continued From page 43 §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. §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.	F 880		

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F 880	Continued From page 44 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, staff interviews and record review the facility failed to follow Centers for Disease Control and Prevention (CDC) recommended use of Personal Protective Equipment (PPE) when Nurse #5 collected COVID-19 nasopharyngeal specimens for Point of Care testing while within 6 feet of 1 of 1 staff member. The facility also failed to ensure proper PPE was utilized when resident care was provided for 1 of 1 residents (Resident #30). Findings included: 1. Documentation on the Centers for Disease Control and Prevention (CDC) guidance entitled, "Interim Guidance For Collecting, Handling, and Testing Clinical Specimen for COVID-19," updated 2/26/21, stated for healthcare providers collecting specimens or working within 6 feet of patients suspected to be infected with SARS-CoV-2, maintain proper infection control and use recommended PPE which includes an N95 or higher lever respirator (or facemask is respirator not available), eye protection, gloves and a gown. It also stated for healthcare providers who are handling specimens, but not directly involved in collection (e.g. handling self-collected specimens) and not working within 6 feet of the patient follow standard precautions. Healthcare providers should wear some source of source control (facemask) at all times while in the healthcare facility. The CDC visual guidance titled "Nasopharyngeal Specimen Collection Steps" ensured recommended PPE was worn when collecting specimens. This included gloves, a gown, eye protection (face shield or goggles) and an N-95 or	F 880	Nurse #5 is no longer working at the facility. NA #2 is no longer working at the facility. Both employees admitted to knowing the proper process for testing and that mask are always to be worn while in the facility; but was focused on their task at hand and had forgotten. On 4/14/2021, the Director of Nursing, Assistant Business office Manager, and/or Director of Rehab visually observed the Dietary, rehab, housekeeping, nursing, and any Administrative staff/visitors entering the facility to ensure all mask were on and worn properly. On 4/14/2021 the Director of Nursing initiated an in service for the Unit Manager on the proper personal protective equipment to utilized during employee and resident COVID 19 testing. On 4/14/2021 the Director of Nursing started re-education to the nursing, housekeeping, rehab, Dietary, and Administrative staff (Social worker, Activities Coordinator, Director of Rehab, central supply, medical records, Food service manager, and minimum data set nurse on COVID 19 policy to include using the CMS recommended KEEP COVD 19 OUT! YouTube video. The Director of Nursing/Staff Development Coordinator/Unit Manager will continue the education to be completed by 5/14/2021. The Director of Nursing and/or Staff Development Coordinator will educate all new hires	

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F 880	Continued From page 45 higher-level respirator (or surgical mask if a respirator is not available). At 9:00 AM on 4/16/21 and observation was made of Nurse #5, who also serves as the facility's Infection Control Nurse, facilitating a COVID-19 nasopharyngeal swab test for COVID-19 testing purposes. She was observed within 6 feet of distance handing the COVID-19 swab to the MDS (minimum Data Set) Nurse without gloves, a face shield or goggles and a gown. She was observed retrieving the swab from the MDS Nurse and placing the COVID-19 swab in the COVID-19 testing device. An interview was conducted with Nurse #5 on 4/16/21 at 9:43 and she stated she does not test on patients, just the employees. She stated most of the employees do specimen self-collection and some employees ask her to do the specimen collection. Nurse#5 stated she was unaware she needed to be wearing that PPE for specimen collection. 2. A review of the facility ' s Infection Control Policy dated 10/27/2020, revised on 11/01/2020, Section, PPE during the COVID-19 Pandemic revealed all staff will wear a surgical mask, goggles and/or face shield and gloves whenever touching the resident ' s skin or surfaces and articles in close proximity to the resident. A continuous observation of Nurse Aide (NA) #2 was completed on 04/12/2021 at 8:25 AM - 8:33 AM. The observation revealed NA #2 entered Resident #30 ' s room and delivered a breakfast tray. NA #2 placed the food tray on Resident #30 ' s bedside table and pushed the bedside table close to Resident #30. NA #2 opened the food tray and eating utensils for Resident #30 and	F 880	during orientation. On 4/14/2021 the Director of Nursing, Admissions Coordinator, Director of Rehab, and/or Assistant Business office Manager initiated a PPE/Employee/Visitor Audit tool. The Admissions Coordinator, Director of Rehab, and/or Assistant Business office Manager will observe 10 employees per audit daily times 5 days, weekly times 7 weeks, then monthly times 1 month; to ensure mask are on and worn properly. Director of Nursing will observe tester for COVID 19 testing weekly X 8 weeks; then monthly X 1 month utilizing the COVID 19 Testing PPE audit. The Administrator will review results of the audits. The Nursing Home Administrator will review the results of the observational Employee/Visitor/PPE audits. Findings will be reported monthly to the QAPI team for review times 3 months. The QAPI Committee can modify this plan to ensure the facility remains in compliance.	

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F 880	Continued From page 46 used the bedside rail to raise the head of the bed to position Resident #30 for eating. NA#2 was wearing gloves, a surgical mask and a KN95 facemask over the surgical mask. Both facemasks were below his nose for the duration of the time he was in the room and prepped Resident #30 for the breakfast meal. An interview with NA #2 on 04/12/2021 at 8:35 am revealed he was agency staff and had received training about the facility infection control practice. He stated the procedure was to wear a mask, goggles and/or face shield and gloves whenever providing patient care, including meal preparation. He stated he had a hard time keeping the facemasks to stay above his nose but thought the mask fitted him fine, they just didn ' t always stay up above his nose. An interview with the Unit Manager on 04/15/2021 at 4:04 pm revealed staff should always wear facemasks covering the nose and mouth. An interview with the Director of Nursing (DON) on 04/15/2021 at 4:17 pm revealed staff should wear facemasks that always cover the entire mouth and nose.	F 880		
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities.	F 919		5/11/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345063	A. BUILDING _____ B. WING _____	C 04/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 919	Continued From page 47 This REQUIREMENT is not met as evidenced by: Based of observations and resident and staff interviews, the facility failed to ensure the call bell was operational for 1 of 11 residents sampled when call lights were checked. (Resident #7) Findings included: Resident #7 was admitted to the facility 3/1/2016, and diagnoses included Hypertension, Diabetes Mellitus, Peripheral Vascular Disease, Rheumatoid Arthritis, Muscle Wasting and Atrophy and Difficulty Walking. The Minimum Data Set (MDS) dated 11/21/20 revealed Resident #7 was cognitively intact, spoke clearly and was easily understood. The MDS further revealed Resident #7 required limited assistance of one person for all activities of daily living except for eating. The care plan dated 1/28/2021 revealed Resident #7 was at risk for falls. Interventions included needing a safe environment with a working and reachable call light and encouraging Resident #7 to use the call bell for assistance as needed. On 4/14/2021 at 10:35am, a Resident Council meeting was conducted. Resident #7 stated his call bell had not worked for two months and he had told the staff. On 4/14/2021 at 12:05pm, a flat circular call bell was observed wrapped around the hand rail on the right side of the bed with the cord lying underneath the bed. A L-shaped plug was observed in the wall unit for the call bell with no cord attached to the plug.	F 919	F919 Call System On 4/14/2021, resident #7 call bell was replaced by the Maintenance Director. On 4/14/2021, current residents call bells were audited by the Maintenance Director and/or Administrative staff to ensure call bells were in good condition and working properly. On 4/14/202, the Administrator in serviced the Maintenance Director on ensuring the call bell system is function properly. On 4/14/2020, Administrator initiated a call bell audit tool to ensure call bell systems is functioning properly. Maintenance Director will ensure call bell system is functioning properly utilizing the Call Bell Audit Tool Weekly X 8 weeks; the monthly X 1 month. The Administrator will review results of the audit. The results of the audits will be presented by Maintenance Director and/or Administrator during the QAPI committee meetings for review and recommendations for a minimum of 3 months and/or substantial compliance is achieved.	

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F 919	Continued From page 48 On 4/14/2021 at 12:05pm when the Activity Director pushed on the call bell, the call light outside Resident #7 ' s room did not turn on. She pulled the cord of the call bell from under the bed, and wires were observed at the end of the cord. She removed the L-shaped plug from the wall unit for the call bell which activated the call light outside the room. The Activity Director stated she would notify the maintenance personnel. On 4/14/2021 at 2:35pm, a push button call bell system was observed plugged into the wall unit for the call bell in Resident #7 ' s room. Resident #7 pushed the button on the call bell, and the call light outside the room lit up. On 04/16/2021 at 9:45am in an interview with the Maintenance Director, he stated he was not aware Resident #7 ' s call bell was not working. He stated equipment in residents ' rooms was checked weekly, and he did not keep a record of residents ' rooms being checked weekly. On 4/16/2021 at 4:32pm in an interview with the Administrator, she stated non-working equipment was fixed immediately when the maintenance director or herself were notified by the residents or staff.	F 919		