STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 05/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

(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 5/24/21/ to 5/27/21. The facility was found in compliance with CFR 483.73, Emergency Preparedness. Event ID# M4ZU11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 5/24/21-5/27/21. Event ID# M4ZU11 8 of the 39 complaint allegations were substantiated resulting in deficiencies.	F 000		
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 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;	F 584		6/21/21

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

Electronically Signed | 06/21/2021

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F 584	Continued From page 1 §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and resident and staff interviews, the facility failed to provide a clean environment by not ensuring a resident ' s room was cleaned for 1 of 23 residents sampled (Resident #57). The findings included: An observation on 5/24/21 at 3:04 PM revealed Resident #57 ' s room had dirt and debris on the floor, a dried, sticky substance on the nightstand, dust on the overbed lighting and dirt and debris over the surface of the windowsill. An interview was conducted with Resident #57 on 5/24/21 at 3:04 PM. She stated that she had money taken from her room a couple of weeks ago and ever since then, the housekeeper wasn ' t allowed in her room and her room hasn ' t been cleaned properly.	F 584	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F584 1. Corrective action for resident(s) affected by the alleged deficient practice: On 05/28/2021, the room for resident #57 was cleaned by the housekeeping staff to include sweeping and mopping of floor,	

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F 584	Continued From page 2 An observation on 5/27/21 at 10:00 AM revealed Resident #57 ' s room still had not been cleaned. There was still debris and dirt on the floor and the windowsill. The dried, sticky substance remained on the nightstand and the overbed lighting was still dusty. An interview with Resident #57 on 5/27/21 at 10:00 AM revealed no one had been in her room to clean it for several days. She stated she couldn ' t remember the last time it was cleaned. On 5/27/21 at 10:45 AM, an interview was conducted with Housekeeper #1. He stated he usually worked on the hall where Resident #57 resided. He stated about 3 weeks ago, Resident #57 alleged someone took money from her and he was suspended while the facility investigated the allegation. He stated since he returned to work, he was not going into Resident #57 ' s room to clean to avoid further misunderstanding. He added he asked the nursing assistants to bring the trash cans out and he emptied those daily and thought another housekeeper might be coming over from another hall to clean the room. On 5/27/21 at 11:58 AM, the Housekeeping Director was interviewed. He stated he usually had someone else come over and clean Resident #57 ' s room and would provide the surveyor his telephone number as he left for the day. On 5/27/21 at 1:49 PM, and interview was conducted with Housekeeping #2. He stated he worked on the 300 hall today and wasn ' t asked to clean Resident #57 ' s room. He was unaware of any arrangement for another housekeeper to go to 200 hall and clean the room.	F 584	nightstand, overbed lighting and windowsills. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice: 100% audit of all rooms in the facility was completed by the administrative staff on 6/18/2021 to ensure that all rooms were cleaned according to policy. Any rooms not cleaned properly were reported to Environmental Director and cleaned per policy. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: All housekeepers will be re-educated by the Environmental Director by 6/18/2021 on cleaning rooms according to policy on regular intervals to include dust mop and damp mop resident room floors, empty trash receptacles, replenish toilet tissue, paper towels, soap, and hand sanitizer. Clean furnishings used by residents and visitors. Clean spot on walls. Complete cleaning of bathrooms. Complete cleaning of window blinds and window sills on regular intervals. Cubicle curtains on regular intervals or as needed. Sanitize beds on deep cleaning schedules. Audits: The Environmental Director or designee will complete weekly audits using the Housekeeping QA Audit Tool to ensure that resident rooms are being cleaned according to policy.	

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F 584	Continued From page 3	F 584	4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. This Housekeeping QA Audit Tool will be completed weekly reviewing 2 rooms on each hall to identify any rooms that have not been cleaned according to policy. This above audit will be completed weekly times 4 weeks then monthly times 3 months or until resolved by Quality Assurance (QA) Committee. Reports will be presented to the monthly QA committee by the Administrator or Environmental Services Director to ensure corrective action was initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the monthly QA Meeting. The monthly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Support Nurses, Therapy, HIM, and Dietary Manager. Date of Compliance: 06/21/2021	
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.	F 600		6/21/21

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F 600	Continued From page 4 §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on Resident interviews, staff interviews, resident observations and record review the facility neglected to provide incontinent care for 1 of 1 sampled residents (Resident #63) who required extensive assistance and who had requested incontinent care on 2 occasions because she had soiled herself. The Resident was observed crying, rocking back and forth and stated she had asked to be changed and nobody had assisted her. The findings included: Resident #63 was admitted to the facility on 10/22/2019 with multiple diagnosis that included acute kidney disease, abnormalities of gait and mobility and anxiety disorder. A review of the Minimum Data Set (MDS) dated 4/27/2021 revealed that the Resident had moderate cognitive impairment, required extensive assistance of one staff member with toileting and personal hygiene and two-person assistance with bed mobility and transfers. She was coded as always incontinent of bowel and bladder. A review of the care plan, revised 4/26/2021, had a focused area identified that the Resident was at risk for skin breakdown and infections due to being incontinent of urine with episodes of	F 600	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F600 1. Corrective action for resident(s) affected by the alleged deficient practice: Resident #63 received incontinent care from NA #7 on 05/24/2021. The facility initiated an investigation on 05/26/2021. There were no adverse effects related to this alleged deficient practice. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice: On 05/28/2021, the Director of Nurses (DON) identified residents who were coded as having some type of incontinence according to their Minimum	

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F 600	Continued From page 5 completely saturating and soaking through incontinence briefs. The goal was for the Resident's risk of complications related to urinary incontinence to be minimized through the current interventions for 90 days. The interventions included, assist Resident with incontinence care, Change bed linens if they are noted with any wetness from urine, change clothing as needed, check for incontinence care every two hours and as needed and provide incontinence care with each incontinent episode, thoroughly cleansing, rinsing and drying perineum. An interview with Resident #63 occurred on 5/24/2021 at 3:40 pm. The Resident stated that she had not been cleaned all day and was wet. Resident #63 went on to say that she had informed the nursing assistant (NA) that she needed help because she was wet, when the NA brought in and picked up her breakfast and lunch trays and again when she came to assist the Resident's roommate. She said she did not recall the NA's name because she was from an agency. The Resident was observed to press the call light at 3:41 PM. An observation of Resident #63 occurred on 5/24/2021 at 3:50 pm, with audible stomach noises, she passed gas and was crying, holding her stomach. The Resident was observed rocking back and forth and to say, I have been wet all day and I need to use the bedpan. Observed the call light, outside of Resident #63's room, on 5/24/2021 at 3:57 pm. The light was observed to be functioning. Observed no staff in the hallway on the 200-hall. An observation was conducted on 5/24/2021 at	F 600	Data Set Assessment. 05/28/2021, the Director of Nurses and the Unit Support Nurses initiated an audit of current residents receiving incontinent care to identify any residents with evidence of neglect from not receiving incontinence care. On 06/10/2021, the Administrator began education of all staff from all departments, full time, part time, agency staff, and PRN staff on the following: • Recognizing and Reporting Abuse including Neglect • Who to report abuse or neglect to • Timeline for Reporting abuse including neglect On 06/15/2021, the DON began education to all Licensed Nurses, Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and Certified Nursing Assistants (CNAs), full time, part time, agency staff, and PRN staff on the following: • Incontinence Care Education • Importance of providing timely incontinence care • Risk associated with a delay in care 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: On 06/10/2021, the Administrator began educating all full time, part time, agency staff, and PRN staff in all departments on the following:	

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F 600	Continued From page 6 4:08 pm. NA #07 provided incontinent care to Resident #63. The Resident was observed wearing a brief, saturated with urine from the front edges to the back edges. A strong urine odor was present. When the NA rolled Resident #63 to her right side, two incontinent pads beneath the Resident were observed to be wet to the edges. NA # 07 removed the Resident's clothing, changed the bedsheet, and provided incontinent care. Observed the Resident to tell NA # 05, thank you because she had been wet all day and no one would come to help her. The Resident stopped crying when incontinence care was provided without the use of a bedpan. An interview was conducted with NA #07 on 5/24/2021 at 4:10 pm as she provided incontinent care to Resident #63. She stated that she changed the bedsheet and the Resident's clothing because they were soaked with urine. On 5/26/2021 at 12:11 pm an interview with the Scheduler was conducted and revealed the assigned NA for Resident #63 on 5/24/2021 day shift, was NA # 06. She added that NA # 06 was from an agency and provided a contact phone number. A review of the 200-hall assignment sheet dated 5/24/2021 documented NA # 06 was assigned rooms 216-221. On 5/26/2021 at 12:20 pm an interview was conducted with Unit Manager #1 and she revealed that incontinence care was not documented for Resident #63 on 5/24/2021, 7 am - 3 pm shift. A telephone interview was conducted with NA #	F 600	• Recognizing and Reporting Abuse including Neglect • Who to report abuse or neglect to • Timeline for Reporting abuse including neglect This information has been integrated into the standard orientation training will be reviewed by the Quality Assurance process to verify that the change has been sustained. As of 06/21/2021 at 5pm, any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed. On 06/15/2021, the DON began education to all Licensed Nurses, Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and Certified Nursing Assistants (CNAs), full time, part time, agency staff, and PRN staff on the following: • Incontinence Care Education • Importance of providing timely incontinence care • Risk associated with a delay in care This information has been integrated into the standard orientation training will be reviewed by the Quality Assurance process to verify that the change has been sustained. As of 06/21/2021 at 5pm, any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed.	

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F 600	Continued From page 7 06 on 5/26/2021 at 3:58 pm. NA #06 stated she was not assigned Resident #63 and did not provide care to the Resident on 5/24/2021. She stated her assignment was rooms 208 - 214. An interview occurred on 5/27/2021 with NA # 05 and she revealed her assignment on 5/24/2021 was rooms 208-215. She stated the assignment sheet for the 200-hall assignment, dated 5/24/2021 was accurate. She added she witnessed NA #06 exit Resident #63's room on 5/24/2021 during the meal tray pick up. An interview was conducted on 5/27/2021 at 9:17 am, with Unit Manager #1 and she revealed her expectation was for an NA to complete necessary care as assigned and if unable, to report to the charge nurse. She denied being aware of a situation or confusion with assignments on 5/24/2021. She stated, after the facilities investigation into the care provided to Resident #63 on 5/24/2021, NA #06 was not allowed to return to the facility and the agency was made aware on 5/26/2021. An interview was conducted with Resident #63 on 5/27/2021 at 9:04 am. When asked how not receiving incontinent care on day shift, 5/24/2021, made her feel, she stated, "not being cleaned up," she then paused, looked down at the ground and added, "why would they do that? Not come and help me? I just don't understand."	F 600	4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Administrator or designee will monitor compliance utilizing the F600 Quality Assurance (QA) Tool weekly x 4 weeks then monthly x 3 months or until resolved by the QA committee. The Administrator will monitor compliance with incontinence care to ensure incontinence care does not rise to the level of neglect. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Nurse, Unit Support Nurses, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 06/21/2021	
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized	F 636		6/21/21

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F 636	Continued From page 8	F 636		

reproducible assessment of each resident's functional capacity.

§483.20(b) Comprehensive Assessments
§483.20(b)(1) Resident Assessment Instrument.
A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:
(i) Identification and demographic information
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

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F 636	Continued From page 9 §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on staff interviews and medical record review, the facility failed to complete an admission Minimum Data Set (MDS) comprehensive assessment within 14 days of the admission date for 1 of 6 residents (Resident # 229) reviewed for timeliness completion of admission MDS assessments. The findings included: Resident #229 was admitted to the facility on 4/30/21 with diagnoses that included, in part, diabetes, congestive heart failure and hypothyroidism. On 5/25/21 at 3:30 PM the admission MDS assessment with an assessment reference date of 5/7/21 was reviewed and revealed the assessment section questions had been answered but had not been signed as completed by the MDS nurse.	F 636	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F 636 COMPREHENSIVE ASSESSMENT & TIMING Corrective Action: Resident #229. Admission Comprehensive Assessment, Assessment Reference Date (ARD) 5/7/2021.	

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F 636	Continued From page 10 An interview was completed with MDS Nurse #1 and MDS Nurse #2 on 5/26/21 at 9:32 AM. MDS Nurse #2 verified Resident #229's admission date was 4/30/21 and said the admission MDS assessment should have been completed and signed by the 14th day, which was 5/13/21. She added MDS staff hadn't signed off the assessment as completed because they were behind schedule. MDS Nurse #1 explained the facility had a high volume of new admissions for rehabilitation services and there were numerous comprehensive assessments that were being completed. During an interview with the Director of Nursing (DON) on 5/26/21 at 11:28 AM she stated the MDS nurses had been supervised by the former Administrator and had recently been placed under the DON's supervision. She shared the MDS assessments should be completed and closed out "on or before the due date." The Corporate Nurse was interviewed on 5/27/21 at 11:36 AM. She explained there was corporate support available to the MDS nurses and time had been scheduled to review the timeliness of assessments and give education to MDS staff regarding regulations.	F 636	Completed, Submitted and Accepted on 6/11/2021 to the State Quality Improvement Evaluation System QIES system Identification of other residents who may be involved with this practice: All current residents with Comprehensive Minimum Data Set (MDS) assessments due have the potential to be affected by the alleged practice. On 6/17/2021 through 6/18/2021 an audit was completed by the MDS Nurse consultant to ensure that the facility had conducted a comprehensive, accurate, standardized reproducible assessment of each resident□s functional capacity. Out of the 78 current residents, 5 number of residents did not have their comprehensive assessments completed within 14 calendar days after admission, excluding readmission in which there is no significant change in the resident□s physical or mental condition. This assessments were completed by 6/25/2021. Systemic Changes: On 6/18/2021 The Registered Nurse (RN) Minimum Data Set (MDS) Coordinator, Licensed Practical Nurse (LPN) Minimum Data Set (MDS) Support nurses any other Interdisciplinary team member that participates in the MDS assessment process was in serviced /educated by the MDS nurse consultant. The education focused on: The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident□s functional capacity.	

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F 636	Continued From page 11	F 636	OBRA-required comprehensive assessments include the completion of both the MDS and the CAA process, as well as care planning. Comprehensive assessments are completed upon admission, annually, and when a significant change in a resident□s status has occurred or a significant correction to a prior comprehensive assessment is required. They consist of: Admission Assessment, Annual Assessment, and Significant Change in Status Assessment (SCSA)and Significant Correction to Prior Comprehensive Assessment (SCPA). The Admission assessment is a comprehensive assessment for a new resident and, under some circumstances, a returning resident that must be completed by the end of day 14, counting the date of admission to the nursing home as day 1 if: this is the resident□s first time in this facility, OR the resident has been admitted to this facility and was discharged return not anticipated, OR the resident has been admitted to this facility and was discharged return anticipated and did not return within 30 days of discharge. The Annual assessment is a comprehensive assessment for a resident that must be completed on an annual basis (at least every 366 days) unless a SCSA or a SCPA has been completed since the most recent comprehensive assessment was completed. Its completion dates (MDS/CAA(s)/care plan) depend on the most recent comprehensive and past assessments□ ARDs and completion dates. Resident Assessment Instrument. A facility must	

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F 636	Continued From page 12	F 636	make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:(i) Identification and demographic information(ii) Customary routine.(iii) Cognitive patterns.(iv) Communication.(v) Vision.(vi) Mood and behavior patterns. (vii) Psychological well-being.(viii) Physical functioning and structural problems.(ix) Continence.(x) Disease diagnosis and health conditions.(xi) Dental and nutritional status.(xii) Skin Conditions. (xiii) Activity pursuit.(xiv) Medications. Special treatments and procedures.(xvi) Discharge planning.(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. This in service was completed by 6/18/2021. Any MDS nurse (full time, part time, and PRN) and member of the interdisciplinary team who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the	

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F 636	Continued From page 13	F 636	Quality Assurance Process to verify that the change has been sustained. Monitoring: To ensure compliance, The Director of Nursing and/or Mini Data Set (MDS) Coordinators will review weekly, 5 residents electronic records Mini Data Set(MDS) assessment this could be either one of the following Comprehensive assessments (Admission Assessment, Annual Assessment, and Significant Change in Status Assessment and Significant Correction to Prior Comprehensive Assessment) to ensure that the comprehensive assessments are completed timely.This will be done on weekly basis to include the weekend for 4 weeks then monthly for 3 months. Reports will be presented to the weekly QA Committee by the Director of Nursing and/or Mini Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, Wound Nurse. Date of Compliance: 6/25/2021	
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility	F 637		6/21/21

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F 637	Continued From page 14 determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a significant change in status Minimum Data Set (MDS) assessment within 14 days after the Assessment Reference Date (ARD) for 1 of 23 residents reviewed (Resident #44). The findings included: Resident #44 was admitted to the facility on 1/22/20 with diagnoses which included Alzheimer's disease and spinal stenosis. A review of Resident #44's quarterly Minimum Data Set (MDS) assessment dated 4/9/21 was conducted. The functional status section of the MDS reported the resident required supervision only for locomotion on/off the unit and for eating (with set-up assist). She needed limited assistance from staff for bed mobility, transfers, walking in her room/corridor, and toileting; and required extensive assistance for dressing and personal hygiene. On 5/26/21, a significant change in status MDS	F 637	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F 637 COMPREHENSIVE ASSESSMENT AFTER SIGNIFICANT CHANGE Corrective Action: Resident #5/10/2021. Significant Change in Status Comprehensive Assessment, Assessment Reference Date (ARD) 5/10/2021. Completed, Submitted and Accepted on 6/4/2021 to the State Quality Improvement Evaluation System QIES system Identification of other residents who may be involved with this practice:	

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F 637	Continued From page 15 with an ARD of 5/10/21 was noted to be "in progress" within the resident's electronic medical record. The functional status section of this MDS reported the resident was independent with eating after set-up assistance. She required extensive assistance for bed mobility and transfers and was totally dependent on staff for dressing, toileting, and personal hygiene. The assessment indicated Resident #44 did not walk in her room/corridor or have any locomotion on/off the unit during the 7-day look back period. The electronic medical record indicated 7 Care Area Assessments (CAAs) were triggered by MDS items responses that indicated the need for additional assessment. Six (6) of the CAAs were noted to be incomplete. The incomplete CAAs included those pertaining to the areas of communication, urinary incontinence, falls, dehydration/fluid maintenance, pressure ulcers, and psychotropic drug use. The electronic record included a notation which read, "Complete by 5/24/21." An interview was conducted on 5/26/21 at 8:16 AM with MDS Nurse #1 as she reviewed Resident #44's significant change MDS assessment. When asked, she confirmed completion of the MDS dated 5/10/21 was late. MDS Nurse #1 reported the CAAs should have been completed by 5/24/21. An interview was conducted on 5/26/21 at 11:15 AM with the facility's Director of Nursing (DON). During the interview, the DON stated her expectation would be for a resident's complete MDS assessment to be done in a timely manner and closed out when it was due.	F 637	All current residents with a Significant Change in Status Comprehensive Minimum Data Set (MDS) assessments due have the potential to be affected by the alleged practice. On 6/17/2021 through 6/18/2021 an audit was completed by the MDS Nurse consultant to ensure that the facility had completed any open Significant Change in Status Comprehensive Minimum Data Set (MDS) assessments within 14days after the Assessment Reference Date (ARD). Out of the 78 current residents, 0 number of residents did not have their comprehensive assessments completed within 14 calendar days after admission, excluding readmission in which there is no significant change in the resident□s physical or mental condition. This audits were completed by 6/18/2021. Systemic Changes: On 6/18/2021 The Registered Nurse (RN) Minimum Data Set (MDS) Coordinator, Licensed Practical Nurse (LPN) Support nurses any other Interdisciplinary team member that participates in the MDS assessment process was in serviced /educated by the MDS Nurse Consultant. The education focused on: The education focused on: The facility must ; Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change"means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by	

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F 637	Continued From page 16	F 637	implementing standard disease-related clinical that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident□s functional capacity. OBRA-required comprehensive assessments include the completion of both the MDS and the CAA process, as well as care planning. Comprehensive assessments are completed upon admission, annually, and when a significant change in a resident□s status has occurred or a significant correction to a prior comprehensive assessment is required. They consist of: Admission Assessment, Annual Assessment, and Significant Change in Status Assessment (SCSA)and Significant Correction to Prior Comprehensive Assessment (SCPA). The Admission assessment is a comprehensive assessment for a new resident and, under some circumstances, a returning resident that must be completed by the end of day 14, counting the date of admission to the nursing home as day 1 if: this is the resident□s first time in this facility, OR the resident has been admitted to this facility and was discharged return not anticipated, OR the resident has been admitted to this facility and was discharged return anticipated and did not return within 30 days of discharge. The Annual assessment is a comprehensive assessment for a resident that must be completed on an annual	

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F 637	Continued From page 17	F 637	basis (at least every 366 days) unless a SCSA or a SCPA has been completed since the most recent comprehensive assessment was completed. Its completion dates (MDS/CAA(s)/care plan) depend on the most recent comprehensive and past assessments□ ARDs and completion dates. Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:(i) Identification and demographic information(ii) Customary routine.(iii) Cognitive patterns.(iv) Communication.(v) Vision.(vi) Mood and behavior patterns. (vii) Psychological well-being.(viii) Physical functioning and structural problems.(ix) Continence.(x) Disease diagnosis and health conditions.(xi) Dental and nutritional status.(xii) Skin Conditions. (xiii) Activity pursuit.(xiv) Medications. Special treatments and procedures.(xvi) Discharge planning.(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. This in service was completed by	

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F 637	Continued From page 18	F 637	6/18/2021. Any MDS nurse (full time, part time, and PRN) and member of the interdisciplinary team who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monitoring: To ensure compliance, The Director of Nursing and/or Mini Data Set (MDS) Coordinators will review weekly, 5 residents electronic records with either two or more areas of decline or two or more areas of improvement ;this may include two changes within a particular domain (e.g., two areas of ADL decline or improvement) in a resident□s condition from his/her baseline has occurred as indicated by comparison of the resident□s current status to the most recent comprehensive assessment and any subsequent Quarterly assessments; and The resident□s condition is not expected to return to baseline within two weeks to ensure that a Significant Change in Status Assessment are completed timely.This will be done on weekly basis to include the weekend for 4 weeks then monthly for 3 months. Reports will be presented to the weekly QA Committee by the Director of Nursing and/or Mini Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate	

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F 637	Continued From page 19	F 637	action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, Wound Nurse. Date of Compliance: 6/25/2021	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to accurately code the medication section on the Minimum Data Set (MDS) assessment for 2 of 5 residents (Resident #42 and Resident #27) reviewed for unnecessary medications. Findings include: 1. Resident #42 was admitted to the facility on 12/3/18 with diagnoses that included, in part, Epilepsy, Abdominal Aortic Aneurysm, and Chronic Obstructive Pulmonary Disease. The quarterly MDS assessment dated 4/6/21 revealed an anticoagulant was coded in the medication section of the MDS. On 5/26/21 at 10:44 AM a record review for unnecessary medications revealed that Resident #42 was not taking any anticoagulants.	F 641	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F641 Accuracy of Assessments Corrective Action: Resident # 42 Resident Minimum Data Set (MDS) assessment (Annual Comprehensive Assessment) with Assessment /Reference Date (ARD) [4/6/2021] was modified with a Corrective Attestation Date of 5/26/2021. The assessment was submitted to the state	6/21/21

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F 641	Continued From page 20 During an interview with MDS Coordinator #1 on 5/26/21 at 3:17 PM, she stated she was unable to find where Resident #42 was on an anticoagulant and that it was coded in error. The Administrator was interviewed on 5/27/21 at 10:57 AM. He shared the facility will be working on educating staff to ensure MDS assessments were accurate. 2) Resident #27 was admitted to the facility on 12/31/19 with re-entry from a hospital on 3/22/21. His cumulative diagnoses included major depressive disorder, adjustment disorder with mixed anxiety and depressed mood, and psychosis not due to a substance or known physiological condition. A review of Resident #27's physician orders included a medication order dated 3/22/21 for 50 milligrams (mg) quetiapine (an antipsychotic medication) to be given as 1 tablet by mouth every night at bedtime. Resident #27's March 2021 and April 2021 Medication Administration Records (MARs) were reviewed. Documentation on the MARs revealed Resident #27 received one dose of 50 mg quetiapine each day from 3/23/21 through 4/1/21. A review of Resident #27's significant change Minimum Data Set (MDS) assessment dated 4/1/21 was conducted. The MDS assessment indicated this resident received an antipsychotic	F 641	QIES system on 5/27/2021 and was accepted on 5/27/2021. Submission ID: 20453429 Resident # 27 Resident Minimum Data Set (MDS) assessment (Significant Change in Status Comprehensive Assessment) with Assessment /Reference Date (ARD) [4/1/2021] was modified with a Corrective Attestation Date of 5/26/2021. The assessment was submitted to the state QIES system on 5/27/2021 and was accepted on 5/27/2021 Submission ID: 20453429 Identification of other residents who may be involved with this practice: All current residents not on anticoagulants, and who are on antipsychotic medications have the potential to be affected by the alleged practice. On 6/17/2021 through 6/18/2021 an audit was completed by the MDS Nurse Consultant to review all Quarterly Minimum Data Set (MDS) assessments in the last 6 months to ensure that all residents who do not use anticoagulants have Section N0410E: Anticoagulant coded accurately. On 6/17/2021 through 6/18/2021 an audit was completed by the MDS Nurse Consultant to review all Significant Change in Status Comprehensive Minimum Data Set (MDS) assessments in the last 6 months to ensure that all residents who use antipsychotics medication have Section N0450: Antipsychotic Medication Review coded accurately. This was completed on 06/18/2021. Systemic Changes: On 06/18/2021 The Registered Nurse	

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F 641	Continued From page 21 medication on 7 out of 7 days during the look back period. However, the Antipsychotic Medication Review was coded to indicate the resident did not receive any antipsychotic medications since his reentry to the facility. An interview was conducted on 5/26/21 at 8:16 AM with MDS Nurse #1. During the interview, MDS Nurse #1 reviewed Resident #27's significant change MDS assessment dated 4/1/21. The nurse confirmed there were discrepancies with the coding of the resident's antipsychotic medication. MDS Nurse #1 reported the information in the Antipsychotic Medication Review was a coding error. She stated, "That was a mistake....I clicked the wrong one." An interview was conducted on 5/26/21 at 11:15 AM with the facility's Director of Nursing (DON). During the interview, the coding error in Resident #27's significant change MDS assessment dated 4/1/21 was discussed. The DON reported she would expect a resident's MDS assessment to be coded accurately.	F 641	(RN) Minimum Data Set (MDS) Coordinator and MDS Support nurse and any other Interdisciplinary team member that participates in the MDS assessment process was in serviced /educated by the MDS Nurse consultant. The education focused on: The facility must ensure that each assessment accurately reflects the resident□s status. Section N0410E, Anticoagulant (e.g., warfarin, heparin, or low- molecular weight heparin): Record the number of days an anticoagulant medication was received by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days). Do not code antiplatelet medications such as aspirin/extended release, dipyridamole, or clopidogrel here. Section N0450: Antipsychotic Medication Review. Review the resident□s medication administration records to determine if the resident received an antipsychotic medication since admission/entry or reentry or the prior OBRA assessment, whichever is more recent. If the resident received an antipsychotic medication, review the medical record to determine if a gradual dose reduction has been attempted. If a gradual dose reduction was not attempted, review the medical record to determine if there is physician documentation that the GDR is clinically contraindicated. Code 0, no: if antipsychotics were not received: Skip N0450B, N0450C, N0450D and N0450E. Code 1, yes: if antipsychotics were received on a routine basis only: Continue	

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F 641	Continued From page 22	F 641	to N0450B, Has a GDR been attempted? Code 2, yes: if antipsychotics were received on a PRN basis only: Continue to N0450B, has a GDR been attempted? Code 3, yes: if antipsychotics were received on a routine and PRN basis: Continue to N0450B, has a GDR been attempted? Any medication that has a pharmacological classification or therapeutic category of antipsychotic medication must be recorded in this section, regardless of why the medication is being used. This in service was completed by 6/18/2021. The Registered Nurse (RN) and or Licensed Practical Nurse (LPN) Support Minimum Data Set (MDS) Coordinators and any other Interdisciplinary team member that participates in the MDS assessment process who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monitoring: To ensure compliance, The Director of Nursing and/or Administrator will review 5 resident electronic medical records Minimum Data Set (MDS) assessment this could be either one of the following assessments Admission, Annual or Quarterly Assessment to ensure that section N0450 and Section N0410E Anticoagulant are coded accurately. This	

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F 641	Continued From page 23	F 641	will be done on weekly basis for 4 weeks then monthly for 3 months. The results of this audit will be reviewed at the weekly QA Team Meeting. Reports will be presented to the weekly QA Committee by the Director of Nursing and/or Mini Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM (Health Information Management), Dietary Manager, Wound Nurse. Date of Compliance: 06/25/2021	
F 677 SS=D	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 observations, staff interviews, and record reviews, the facility failed to provide staff encouragement and/or assistance with eating for a resident identified to have experienced a significant decline in ADL physical functioning; and, failed to assist a resident to put his dentures in his mouth prior to meal service. This occurred for 2 of 9 residents (Resident #44 and Resident #379) reviewed for Activities of Daily Living.	F 677	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of	6/21/21

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F 677	Continued From page 24 The findings included: 1) Resident #44 was admitted to the facility on 1/22/20 from a hospital. The resident ' s cumulative diagnoses included Alzheimer's disease. The resident ' s admission orders included a diet order dated 1/22/20 for a Regular diet with regular textures and fortified foods (foods containing added calories and protein). On 4/2/20, a physician's order was received to provide 90 milliliters (ml) of Med Pass 2.0 (a high calorie, high protein nutritional supplement) at bedtime to assist with her oral intake and wound healing. The resident ' s electronic medical record (EMR) included the following weights, in part: --12/8/20 weight = 102.0 pounds (#); --2/2/21 weight = 99.4 #; --3/1/21 weight = 100.6 #. Resident #44's care plan included the following areas of focus, in part: --I have a potential nutritional problem related to a history of weight loss, fair meal intake (Initiated on 2/27/20; revision on 4/9/21). The planned interventions included observe for / record / report to her physician as needed for any signs/symptoms of malnutrition such as emaciation or significant weight loss (Initiated 7/22/20); Provide, serve diet as ordered and monitor/record every meal (Initiated 2/27/20; revised on 7/22/20); Registered Dietitian (RD) to evaluate and make diet change recommendations as needed (Initiated 2/27/20; revision on 7/22/20); Weigh per MD orders	F 677	compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F677 1. Corrective action for resident(s) affected by the alleged deficient practice: Resident #44 was assisted with her meal intake by staff on 5/25/2021. On 06/17/2021 the Care plan and task was updated to reflect the required meal assistance by the Minimum Data Set Nurse (MDS). Resident #379 was discharged to home on 5/25/2021, therefore no corrective action could be completed for him. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents in the facility who require assistance with meals and residents who need assistance with application of their dental appliances have the potential to be affected. On 06/14/2021, the Director of Nurses (DON), Unit Support Nurses, and the Minimum Data Set Nurse (MDS Nurse) initiated an audit of all current residents to identify residents who require assistance with meals. The audits were completed on 06/18/2021. The CNA task was updated to notify staff of all current residents who require assistance with meals. All residents who require assistance with meals had their care plan and the Kardex updated to reflect the need for meal assistance. On 06/14/2021, the DON, Unit Support	

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F 677	Continued From page 25 (Initiated 2/27/20; revision on 7/22/20). Meal Intake Records from 3/1/21 through 3/31/21 documented the amount eaten by Resident #44 as follows: --75-100% of the meal was documented as eaten for 53% of the resident's meals; --51-75% of the meal was documented as eaten for 40% of the resident's meals; --26-50% of the meal was documented as eaten for 5% of the resident's meals; --0-25% of the meal was documented as eaten for 2% of the resident's meals. Meal Intake Records from 4/1/21 through 4/9/21 documented the amount eaten by Resident #44 as follows: --75-100% of the meal was documented as eaten for 33% of the resident's meals; --51-75% of the meal was documented as eaten for 38% of the resident's meals; --26-50% of the meal was documented as eaten for 29% of the resident's meals; --None of the meals were documented to have less than 25% meal eaten. A review of Resident #44 ' s quarterly Minimum Data Set (MDS) assessment dated 4/9/21 was conducted. The MDS revealed the resident had severely impaired cognitive skills for daily decision making. No rejection of care was reported. The functional status section of the MDS reported the resident required supervision only for locomotion on/off the unit and for eating (with set-up assist). She needed limited assistance from staff for bed mobility, transfers, walking in her room/corridor, and toileting; and required extensive assistance for dressing and personal hygiene. The nutrition status section of	F 677	Nurses, and the MDS Nurse initiated an audit of all current residents to identify residents who require assistance with denture application. The audits were completed on 06/18/2021. The CNA task was updated to notify staff of all current residents who require assistance with denture application. All residents who have dentures had denture care entered in the resident□s care plan and the Kardex. On 06/14/2021, the DON initiated the following education to all Licensed Nurses, Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and Certified Nursing Assistants (CNAs), full time, part time, agency staff, and PRN staff: " General Activities of Daily Living (ADL) care to include meal intake and oral care 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: On June 14, 2021, the DON initiated ADL education to all Licensed Nurses, RNs, LPNs, and CNAs, full time, part time, agency staff, and PRN staff. As of 06/21/2021 at 5 PM, any employee who has not received this education will not be allowed to work until the training has been completed. This includes licensed nurses and nursing assistants full time, part time,	

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F 677	Continued From page 26 the MDS reported the resident was 60 inches tall and weighed 101 #. Meal Intake Records from 4/9/21 through 4/30/21 documented the amount eaten by Resident #44 as follows: --75-100% of the meal was documented as eaten for 37% of the resident's meals; --51-75% of the meal was documented as eaten for 39% of the resident's meals; --26-50% of the meal was documented as eaten for 20% of the resident's meals; --0-25% of the meal was documented as eaten for 4% of the resident's meals. Meal Intake Records from 5/1/21 through 5/10/21 documented the amount eaten by Resident #44 as follows: --75-100% of the meal was documented as eaten for 18% of the resident's meals; --51-75% of the meal was documented as eaten for 59% of the resident's meals; --26-50% of the meal was documented as eaten for 17% of the resident's meals; --0-25% of the meal was documented as eaten for 6% of the resident's meals. A significant change MDS with an Assessment Reference Date (ARD) of 5/10/21 was noted as "in progress" by the resident's electronic medical record. The MDS revealed the resident had severely impaired cognitive skills for daily decision making. No rejection of care was reported. The functional status section of this MDS assessment reported the resident was independent with eating after set-up assistance. She was reported as requiring extensive assistance for bed mobility and transfers and was totally dependent on staff for dressing, toileting,	F 677	agency staff, and PRN staff. The in-service will be incorporated into the new employee facility orientation. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The DON or designee will monitor compliance utilizing the F677 Quality Assurance Tool weekly for 4 weeks then monthly x 3 months or until resolved by the QA committee. The DON will monitor to ensure that dependent residents receive assistance with meal intake and dependent residents receive assistance with denture application. Reports will be presented to the weekly Quality Assurance committee by the DON to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting or until deemed not necessary for compliance with ADL Care. The weekly QA Meeting is attended by the Administrator, DON, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 06/21/2021	

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and personal hygiene. The assessment indicated Resident #44 did not walk in her room/corridor or have any locomotion on/off the unit during the 7-day look back period. The nutrition status section of the MDS reported the resident weighed 98 #.

Meal Intake Records from 5/10/21 through 5/24/21 documented the amount eaten by Resident #44 as follows:
--75-100% of the meal was documented as eaten for 26% of the resident's meals;
--51-75% of the meal was documented as eaten for 37% of the resident's meals;
--26-50% of the meal was documented as eaten for 22% of the resident's meals;
--0-25% of the meal was documented as eaten for 15% of the resident's meals.

An observation was made on 5/24/21 at 12:23 PM as Resident #44's noon meal tray was delivered to her. The resident was sitting in a wheelchair in her room. The meal tray was placed on the resident ' s tray table in front of her wheelchair and meal set-up was provided. However, no further staff assistance with the meal was observed at that time. On 5/24/21 at 12:35 PM, a continuous observation was made from the hallway as the resident appeared to pay very little attention to her meal; no staff members entered the room to provide encouragement or assistance for Resident #44's meal. At 12:38 PM, a Nursing Assistant (NA) was observed as she walked down the hall past the resident's room, turned her head to the left appearing to look into the resident's room as she passed by. Immediately after the NA passed Resident #44's room, a direct observation was conducted of Resident #44 with her wheelchair turned away

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from the meal tray on her bedside tray table. At that time, she was facing her dresser; she was not attempting to eat or drink anything from her meal tray. At 12:43 PM, the resident was again observed to be turned away from the meal tray and facing her dresser. At 12:48 PM, Resident #44's meal tray was closely observed to reveal she had eaten only a few bites from her noon meal. She was then observed to propel her wheelchair next to her bed and away from the meal tray placed on her tray table. On 5/24/21 at 1:00 PM, NA #8 entered Resident #44's room and exited within 1-2 minutes with the resident's meal tray. No conversation between the NA and resident could be overheard from the hallway.

On 5/24/21 at 2:54 PM, an interview was conducted with NA #8. During the interview, the NA was asked how much she thought Resident #44 had eaten at lunchtime. The NA confirmed she picked up Resident #44's meal tray at the end of the meal service and reported she estimated the resident ate less than 25% of the meal. The NA stated she didn't know if it was the food or if the resident needed help with feeding. When asked, the NA reported she only picked up the noon meal tray and did not attempt to assist Resident #44 with her meal.

An observation was conducted on 5/25/21 at 8:05 AM as Resident #44 was lying in bed asleep when the breakfast meal cart had been delivered to the hall. At 8:18 AM, the resident was observed to be sitting with her head of bed raised and her breakfast tray sitting on the tray table in front of her. Resident #44 was asleep. No staff member was in the room. A continuous observation was made of the resident ' s room from hallway. At 8:32 AM, the resident remained

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asleep; her breakfast meal tray was on her bedside tray table. No staff member was in the room. Observations conducted at 8:42 AM, 8:45 AM and 8:55 AM revealed Resident #44 remained asleep in bed. No food or fluids had been touched on her breakfast tray. No staff member was in the room. On 5/25/21 at 9:07 AM, NA #9 was observed as she entered the resident's room. She exited the room within one minute while carrying Resident #44's breakfast tray. The NA placed the tray on the meal cart used to transport trays back to the kitchen.

An interview was conducted on 5/25/21 at 9:08 AM with NA #9. During the interview, a request was made to pull the resident ' s tray out of the meal cart to see how much she had eaten. At that time, NA #5 joined the observation and discussion. NA #5 lifted the lid off of Resident #44's breakfast plate so the entire meal could be observed. NA #5 stated, "She didn't eat anything." This NA reported staff needed to get something else for Resident #44 to eat and to see if the resident could be assisted by staff with her meal.

An interview was conducted on 5/26/21 at 8:16 AM with MDS Nurse #1. During the interview, MDS Nurse #1 reported a significant change in status MDS assessment (with an ARD of 5/10/21) was in process because the resident had been identified as having a recent decline in her condition. Upon inquiry, the MDS Nurse stated the resident was coded on the MDS assessment as being independent for eating based on information put into the electronic Kiosk by the NAs.

An interview was conducted on 5/26/21 at 11:15

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AM with the facility's Director of Nursing (DON). During the interview, the observations of Resident #44's poor meal intake and failure of the staff to provide encouragement and/or assistance at mealtime were discussed. The DON reported she would follow-up on the concern to ensure staff were doing whatever was needed for the resident. Upon further inquiry, the DON stated her expectation would be for staff to attempt to assist the resident with his/her meal if they saw someone who had not eaten. If the resident's poor intake was "a constant thing," she would want staff to notify the Unit Manager so the situation could be addressed.

2. Resident # 379 was admitted to the facility on 5/5/2021 with multiple diagnoses that included: Pathological fracture in neoplastic disease of the hip and anemia.

A review of the nurse admission assessment dated 5/5/2021 revealed Resident #379 was admitted with upper and lower dentures and the dentures were required to eat. The Resident was assessed to be cognitively intact and able to communicate his needs. The admission Minimum Data set (MDS) was in process at the time of the record review.

A review of the plan of care created 5/5/2021 documented an identified focused area for at risk for nutritional deficit related to receiving a mechanically altered diet, and Activities of Daily Living self- care deficit. Interventions included Resident # 379 required staff assistance with grooming/personal hygiene. Dentures were not indicated on the plan of care.

An observation occurred on 5/24/2021 at 10:18

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AM of Resident # 379 lying in bed with no teeth in place. A denture cup with an upper and lower set of teeth was observed on the bathroom sink counter with a label for the Resident on the outside of the cup.

An observation of the noon meal on 5/24/2021 at 12:21 PM revealed the Resident was lying in bed, with the head of the bed elevated and the meal tray set up in front of him. He was chewing and spit out his meat three times. The meal ticket documented easy to chew food only. The food on the tray was pre-cut chicken with gravy, mash potatoes and spinach. The resident did not have dentures in place.

An interview with Resident # 379 at 12:23 PM on 5/24/2021 during the noon meal observation was conducted. The Resident stated he always needed his teeth to eat but the past few weeks he had not been receiving help with placing them in prior to meals.

On 5/24/2021 at 12:35 PM an interview was conducted with Nursing Assistant #7 occurred and she stated she had not had time on to review the Kardex (a tool used by nursing administration staff to communicate resident care needs to direct clinical care staff) for Resident #379 yet. She denied knowing the Resident required dentures for meals and added that she had not placed them in for the morning meal either. She was then observed to retrieve the dentures and assist the resident with placement.

An interview was conducted with Unit Manager #1 on 5/26/2021 at 12:20 PM and she revealed it was her expectation that residents with dentures receive assistance with placing dentures into their

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F 677	Continued From page 32 mouth prior to meal delivery.	F 677		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and physician interviews, the facility failed to follow a physician ' s order when providing pressure ulcer care for 1 of 3 residents reviewed for pressure ulcers (Resident #183). The findings included: Resident #183 was admitted to the facility on 4/26/21 with an unstageable pressure ulcer to his sacrum. A 5-day Minimum Data Set (MDS) assessment dated 4/29/21 revealed Resident #183 required extensive assistant with bed mobility and transfers, was frequently incontinent of bladder and had an ileostomy. Resident #183 was at risk of developing pressure ulcers and had a current	F 686	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F686 1. Corrective action for resident(s) affected by the alleged deficient practice: For resident #183, on 05/28/2021 the Registered Nurse (RN) completed wound	6/21/21

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F 686	Continued From page 33 unstageable pressure ulcer. Resident #183 was receiving pressure ulcer treatment. An initial wound evaluation and management summary dated 4/27/21 revealed Resident #183 had an unstageable pressure ulcer to his sacrum that measured 1.4 x 4.8 centimeters. The treatment plan was to apply santyl and calcium alginate and cover with a dry protective dressing daily for 30 days. A physician ' s order dated 5/13/21 read, clean sacrum with normal saline or wound cleanser, apply antifungal to reddish dry area surrounding wound, then apply santyl and calcium alginate and cover with dry gauze and small abdominal pad daily for 15 days. On 5/224/21, Resident #183 was seen by the wound care physician. The treatment to clean the sacrum area with normal saline or wound cleanser and apply santyl and calcium alginate remained in place. On 5/25/21 at 10:06 AM, a wound care observation was conducted on Resident #183 ' s sacral wound. Treatment Aide #1 removed Resident #183 ' s soiled dressing to his sacrum. The soiled dressing contained a moderate amount of dark colored drainage. Treatment Aide #1 then cleaned the wound with normal saline, applied the antifungal to the reddened areas around the wound, applied santyl (a debriding agent) to the wound bed and covered the area with a dry dressing. Treatment Aide #1 was not observed to apply calcium alginate to the wound per the physician ' s order. On 5 ' 25/21 at 2:42 PM, Treatment Aide #1 was	F 686	observation with the Treatment Aide ensuring that the wound care was completed according to the physician□s order using the correct techniques. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 05/28/2021, the RN treatment nurse audited all current residents with treatments including residents with specific orders containing calcium alginate and to ensure that other treatments were performed according to the physician□s order and any dressings ordered were in place and intact. This was completed on 05/28/2021. On 05/28/2021, the Director of Nursing (DON) began educating all Licensed Nurses, RNs, Licensed Practical Nurses, and any Treatment Aides, full time, part time, agency staff, and PRN on the following topics: " Carrying out the prescribed treatment order for pressure ulcers. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 05/28/2021, the Director of Nursing (DON) began educating all Licensed Nurses, RNs, Licensed Practical Nurses, and any Treatment Aides, full time, part time, agency staff, and PRN on the following topics:	

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F 686	Continued From page 34 interviewed. She stated she didn ' t know the treatment order included calcium alginate, she did not see that in the order. On 5/27/21 at 11:10 AM, the wound care physician was interviewed. He stated not applying the calcium alginate to the wound would not harm it but, he used it to manage the drainage from the wound and keep it dry so should applied.	F 686	" Carrying out the prescribed treatment order for pressure ulcers. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by June 21, 2021. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The DON or designee will monitor compliance utilizing the F686 Quality Assurance Tool weekly x 4 weeks then monthly x 3 months. The DON will monitor compliance to ensure pressure ulcer treatments are carried out according to the physician□s order. Reports will be presented to the weekly Quality Assurance committee by the DON to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Unit Support Nurses, Therapy Manager, Health Information Manager, and the Dietary Manager.	

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F 686	Continued From page 35	F 686	Date of Compliance: June 21, 2021	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record reviews, the facility failed to implement fall safety interventions developed and care planned by its interdisciplinary team (IDT) for 1 of 4 residents (Resident #38) reviewed for accidents. The findings included: Resident #38 was admitted to the facility on 9/4/19 with re-entry from a hospital on 2/27/20. Her cumulative diagnoses included non-Alzheimer's dementia, polymyalgia rheumatica (an inflammatory disorder that causes muscle pain and stiffness), and a history of repeated falls. Resident #38 ' s most recent Minimum Data Set (MDS) was a significant change in status assessment dated 4/2/21. The MDS reported the resident was assessed by staff as having severely impaired cognitive skills for daily decision making. She had no behaviors but was reported to have rejection of care on 1 - 3 days	F 689	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F689 1. Corrective action for resident(s) affected by the alleged deficient practice: On 05/25/2021, for resident #38, the fall mat was placed on the right side of the resident□s bed. On 05/25/2021, the CNA task was updated to include fall mat on both sides of the bed. 2. Corrective action for residents with	6/21/21

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F 689	Continued From page 36 out of the 7-day look back period. The MDS indicated Resident #38 required extensive assistance for all of her Activities of Daily Living (ADLs), with the exception of being totally dependent on staff for bathing. The MDS assessment revealed the resident had two or more falls with injury (not major) since her prior assessment. The resident ' s Care Plan included the following area of focus: I am at an increased risk for falls related to deconditioning., history of falls, psychoactive drug use, and history of wandering with actual falls (Date Initiated: 9/12/19; Revision on: 3/8/21). The planned interventions on this care plan related to falls included: --Keep frequently used objects within my reach as much as possible (Date Initiated: 9/12/19); --Do not leave resident unattended during toileting (Date Initiated: 2/27/20; Revision on: 3/3/21); --Dycem (a non-slip surface) under and on top of wheelchair cushion (Date Initiated: 4/13/20; Revision on: 4/17/20); --Non-slip Socks when out of bed and not wearing shoes as tolerated (Date Initiated: 6/18/20; Revision on: 6/18/20); --Bed in lowest position (Date Initiated 8/6/20); --Clarify settings of air mattress (Date Initiated: 3/23/21); --Nurse Practitioner to evaluate for pain medication needs (Date Initiated: 3/28/21); --Follow hospital discharge summary recommendations (Date Initiated: 4/16/21); --Review air mattress setting (Date Initiated: 5/2/21). On 5/14/21 at 8:44 PM, a Fall/Incident Report indicated staff responded to Resident #38 ' s	F 689	the potential to be affected by the alleged deficient practice. Beginning on 06/03/2021, the Director of Nurses (DON), Unit Support Nurses, and the Minimum Data Set Nurse (MDS Nurse) initiated an audit of all current residents with falls in the past 30 days to ensure interventions documented on the incident report were entered in the care plan and CNA task. This audit was completed on 06/11/2021. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 06/03/2021, the Clinical Nurse Consultant educated the DON and Unit Support Nurses on the following topics: " Ensuring that fall interventions are entered into CNA task/Kardex timely. " Ensuring that falls interventions are put into place timely. On 06/14/2021, the DON educated the MDS on the following topics: " Ensuring that fall interventions are entered into CNA task/Kardex timely. " Ensuring that falls interventions are put into place timely.	

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F 689	Continued From page 37 roommate yelling out the resident was lying on the floor. Upon staff arrival to the room, the resident was observed to be lying on the right side of the bed with the bed linen pulled downward. The bed was reported to be in the lowest position and a fall mat was placed on the left side of the bed. However, the resident fell on the right side of the bed (the side without a fall mat). When the resident was asked what happened, she reported she hit her head and complained of pain. The resident was transported to the ED for evaluation and treatment. On 5/18/21, Resident #38's fall on 5/14/21 was reviewed by the IDT with a recommendation made to place fall mats on both sides of her bed. Further review of Resident #38's Care Plan revealed it had been revised to include a new intervention under the care area related to falls. The interventions were revised to include placing a fall mat on both sides of the bed while the resident was in bed (Date Initiated: 5/17/21; Revision on: 5/24/21). An observation was conducted on 5/24/21 at 1:23 PM of Resident #38 lying in her bed. The resident's air mattress was on; her bed was in the low position; and, a fall mat was placed on the left side of her bed. No fall mat was placed on the right side of the bed. A second fall mat was not observed to be present in the room. The resident was not interviewable. An observation was conducted on 5/25/21 at 8:05 AM of Resident #38 lying in her bed asleep. The resident's air mattress was on; her bed was in the low position; and, a fall mat was placed on the left side of her bed. No fall mat was placed on the	F 689	On 06/11/2021, the DON initiated the following education to all Licensed Nurses, Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and Certified Nursing Assistants (CNAs), full time, part time, agency staff, and PRN staff: " Reviewing the kardex for fall interventions. This information has been integrated into the standard orientation training for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. As of 06/21/2021 by 5pm, any nursing staff who does not receive scheduled in-service training will not be allowed to work. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing or designee will monitor compliance utilizing the F689 Quality Assurance Tool weekly x 4 weeks then monthly x 3 months. The Director of Nursing will monitor to ensure fall interventions are in place and carried out timely. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program	

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F 689	Continued From page 38 right side of the bed. A second fall mat was not observed to be present in the room. An observation was conducted on 5/25/21 at 10:30 AM of Resident #38 lying in her bed asleep. The resident ' s air mattress was on; her bed was in the low position; and, a fall mat was placed on the left side of her bed. No fall mat was placed on the right side of the bed. An interview was conducted on 5/26/21 at 8:16 AM with the MDS Nurse #1. During the interview, the MDS Nurse discussed the facility's process for reviewing a resident after he/she has experienced a fall. The nurse stated falls were discussed during the daily clinical meetings on Monday through Friday each week. These meetings typically involved the facility's Director of Nursing (DON), Unit Manager(s), therapy staff, and MDS Nurse(s). At that time, potential interventions to promote the resident's safety were discussed. If a new intervention was implemented, the MDS nurse was responsible to put the changes/revisions into the resident's care plan. Accompanied by MDS Nurse #1, an observation was made of Resident #38 on 5/26/21 at 8:43 AM. The resident was observed to be lying in her bed with the head of bed raised and a Nursing Assistant (NA) sitting down near the right side of the bed assisting the resident with her breakfast. The bed was in the low position; a pillow was on the left side of her trunk; and a fall mat was placed on the left side of the bed. No fall mat was placed on the right side of the bed. Upon inquiry, MDS Nurse #1 confirmed she did not see a second fall mat available for use in the resident's room. The nurse stated whatever was	F 689	reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Unit Support Nurses, Health Information Manager, and the Dietary Manager. Date of Compliance: 06/21/2021	

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F 689	Continued From page 39 put into the care plan as an intervention should have been exactly what was implemented. When asked, MDS Nurse #1 stated it was a concern that the care plan intervention was not implemented. An interview was conducted on 5/26/21 at 11:15 AM with the facility's Director of Nursing (DON). During the interview, the observations of Resident #38's fall care plan interventions were discussed. The DON stated new care plan interventions were communicated to the direct care nursing staff when they were put into the care plan system. She explained that usually when the interventions were care planned, they were put in so they would be carried over into the Care Guide (available via the electronic Kiosk for Nursing Assistants). The DON also reported she would expect the Unit Manager to ensure new care plan interventions were put into place for a resident.	F 689		
F 757 SS=E	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or	F 757		6/21/21

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F 757	Continued From page 40 §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interviews, a telephone interview with the facility's consultant pharmacist, and record reviews, the facility failed to monitor for the potential adverse effects of metoclopramide administration (a medication which may be used to treat nausea or indigestion) by completing Abnormal Involuntary Movements (AIMS) assessments on a routine basis for 1 of 5 residents (Resident #44) reviewed for unnecessary medications. The findings included: Resident #44 was admitted to the facility on 1/22/20 from a hospital. The resident's cumulative diagnoses included Alzheimer's disease and gastroesophageal reflux disease. A review of Resident #44's admission medications dated 1/22/20 included 5 milligrams (mg) metoclopramide to be administered three times daily for acid reflux. Metoclopramide is a medication which contains a black box warning. A black box warning is the U.S. Food and Drug Administration's most stringent warning for drugs on the market. The boxed warning highlights the risk of tardive dyskinesia (involuntary and repetitive movements of the body) with long-term or high-dose use of	F 757	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F757 Corrective action for resident(s) affected by the alleged deficient practice: On 05/27/2021, the AIMS was completed for resident #44 by the Unit Support Nurse. Corrective action for residents with the potential to be affected by the alleged deficient practice. Beginning on 05/27/2021, the Director of Nurses (DON) and the Unit Support Nurses initiated an audit of all current residents receiving Reglan to identify the last completed AIMS assessment and to ensure that the AIMs was entirely completed. This audit was completed on 05/28/2021. Measures /Systemic changes to prevent	

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F 757	Continued From page 41 metoclopramide, even after the drug is no longer taken. An AIMS assessment is used to monitor a resident receiving metoclopramide to detect tardive dyskinesia and to follow the severity of a patient's tardive dyskinesia over time. On 1/23/20, an AIMS assessment was conducted for Resident #44. At that time, the assessment noted the resident had no facial/oral movements, extremity movements or trunk movements. However, Section D of the assessment entitled "global movements" was not completed. Section G "Evaluation" of the AIMS assessment noted, "Resident has no single score exceeding Minimal, Low Risk for movement disorder - continue to monitor according to policy." The facility's consultant pharmacist completed a monthly Medication Regimen Review (MRR) on 6/9/20. The pharmacist's note requested evaluation for reduction of the metoclopramide. On 6/16/20, a physician's order was received to reduce the dosing schedule of 5 mg metoclopramide from three times daily to twice daily. The consultant pharmacist completed a monthly MRR on 9/9/20. Her recommendations included completion of an AIMS assessment to monitor the potential effects of metoclopramide. On 10/9/20, a second AIMS assessment was conducted for Resident #44. This assessment noted the resident had no facial/oral movements, extremity movements, trunk movements, or global movements. However, Section G of the assessment (Evaluation) was not completed and the assessment was not scored.	F 757	reoccurrence of alleged deficient practice: On 05/28/2021, the Clinical Nurse Consultant provided an in-service to the DON, Minimum Data Set Nurse (MDS), and Unit Support Nurses on the following topics: " Completing AIMs assessment according to facility policy. " Completion of the AIMs assessment in its entirety. " Completion of all pharmacy recommendations timely. This information has been integrated into the standard orientation training for nurse management team and will be reviewed by the Quality Assurance process to verify that the change has been sustained. As of 06/21/2021 at 5pm, any nurse management staff who does not receive scheduled in-service training will not be allowed to work until training has been completed. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing or designee will monitor compliance utilizing the F757 Quality Assurance Tool weekly x 4 weeks then monthly x 3 months. The Director of Nursing will monitor for compliance with completion of AIMs assessment in its entirety according to facility policy for all residents on Reglan. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will	

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F 757	Continued From page 42 During a monthly MRR conducted on 1/8/21, the consultant pharmacist recommended an AIMS assessment be repeated to monitor for the effects of metoclopramide administered to Resident #44. This same recommendation was made in the MRR notations written by the pharmacist on 3/5/21 and 4/8/21. A review of Resident #44's most recent Minimum Data Set (MDS) was a quarterly assessment dated 4/9/21. The MDS revealed the resident had severely impaired cognitive skills for daily decision making. Section G of the MDS reported the resident required supervision only for locomotion on/off the unit and for eating (with set-up assist). She needed limited assistance from staff for bed mobility, transfers, walking in her room/corridor, and toileting; and required extensive assistance for dressing and personal hygiene. The consultant pharmacist's monthly MRR dated 5/8/21 once again recommended completion of an AIMS assessment to monitor the potential effects of metoclopramide administered to Resident #44. A telephone interview was conducted with the facility's consultant pharmacist on 5/27/21 at 11:20 AM. During the interview, the pharmacist reported she expected to see AIMS testing completed every three (3) months for a resident receiving either an antipsychotic medication or metoclopramide. When asked how she communicated her recommendations to the facility, the pharmacist reported she emailed her monthly recommendations to the Director of Nursing (DON) to be shared with the prescriber.	F 757	be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Unit Support Nurses, Health Information Manager, and the Dietary Manager. Date of Compliance: June 21, 2021	

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F 757	Continued From page 43 Upon further inquiry, the pharmacist stated she would expect a response or action related to her recommendation within a month (before she returned for the next monthly review). An interview was conducted on 5/27/21 at 2:00 PM with Unit Manager #1, who was responsible for the nursing unit caring for Resident #44. Unit Manager #1 was also identified as the nurse who had conducted the AIMS assessments for this resident on 1/23/20 and 10/9/20. During the interview, the Unit Manager reported the admitting nurse typically completed a resident's AIMS assessment when it was due. If the admitting nurse did not complete the assessment, it became her responsibility to do so. Upon review of the AIMS assessments done on 1/23/20 and 10/9/20, Unit Manager #1 stated she did not know why they were incomplete. When asked, she reported if the last AIMS assessment was done on 10/9/20, the next one would need to be done in 3 months (January 2021). Unit Manager #1 reported she had not been made aware the consultant pharmacist's recommendations indicated additional AIMS assessments were due to be completed for Resident #44. An interview was conducted on 5/27/21 at 2:30 PM with the facility's Director of Nursing (DON). During the interview, the DON reported she received the consultant pharmacist's monthly recommendations and would typically pass them along to the Unit Managers to be addressed. She stated, "I would expect it (referring to the AIMS assessments) to be completed."	F 757		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		6/21/21

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F 761	Continued From page 44 §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to date opened medications to allow for the determination of a shortened expiration date in accordance with the manufacturer's instructions in 1 of 2 medication carts observed (200 Hall Med Cart); and, failed to discard an expired medication in 1 of 1 medication storage room observed (100/200 Hall Med Room). The findings included: 1-a) In the presence of Nurse #2, an observation	F 761	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.	

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F 761	Continued From page 45 was conducted of the 200 Hall Med Cart on 5/24/21 at 3:20 PM. The observation revealed an opened 62.5 microgram (mcg) Incruse Ellipta Inhaler (a medication used for the treatment of chronic obstructive pulmonary disease or COPD) dispensed for Resident #27 on 1/12/21 was stored on the medication cart. The inhaler was placed inside the manufacturer ' s box. Storage instructions on the box read, "Discard the inhaler 6 weeks after opening the moisture-protective foil tray or when counter read "0" whichever comes first. Neither the inhaler nor the manufacturer ' s box indicated when the inhaler had been opened and removed from the moisture-protective packaging. An interview was conducted with Nurse #2 on 5/24/21 at 3:25 PM. During the interview, the nurse confirmed he did not know when the inhaler was opened because it had not been dated. A review of Resident #27's May 2021 Medication Administration Record (MAR) revealed he had a current order for 62.5 mcg/inhalation Incruse Ellipta to be given as 1 puff inhaled orally one time a day related to COPD. An interview was conducted on 5/26/21 at 11:15 AM with the facility's Director of Nursing (DON). The findings of the Medication Storage task were discussed during the interview. When asked, the DON stated the Incruse Ellipta Inhaler should have been dated when the foil pouch was opened because it would only have been good for six weeks after opening. 1-b) In the presence of Nurse #2, an observation was conducted of the 200 Hall Med Cart on 5/24/21 at 3:20 PM. The observation revealed an	F 761	F761 1. Corrective action for resident(s) affected by the alleged deficient practice: Resident #27, the Incruse Ellipta Inhaler was removed and discarded. A new inhaler was obtained and dated when opened. Resident #57, the Insulin Lispro pen was removed and discarded. The Lantus Insulin pen was removed and discarded. A new Insulin Lispro pen and a new Lantus Insulin pen was obtained and dated when opened. The identified expired meds were discarded on 05/27/2021 by the Director of Nurses (DON). The expired unopened bottle of garlic tablets was removed and discarded on 05/24/2021 by Nurse #1. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents in the facility who take medications have the potential to be affected. Beginning on 06/02/2021, the Unit Support Nurses audited all medication carts, treatment carts, and medication rooms to identify any expired or undated medications. Corrections were made immediately where indicated. This was completed on 06/02/2021. Beginning on 06/06/2021, the Central Supply Clerk completed an audit of the	

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F 761	Continued From page 46 opened insulin lispro prefilled pen dispensed for Resident #57 was stored on the med cart. No pharmacy dispensed date was visible on the label of the insulin pen. Nothing was written on the white pharmacy auxiliary sticker placed on the pen which read, "Date Open." When asked, Nurse #2 confirmed no date was written on the insulin pen to indicate when it had been placed on the med cart at room temperature or as to when it had been opened. A review of the manufacturer's storage instructions indicated insulin lispro prefilled pens may be stored at room temperature for 28 days; prefilled pens that have been opened (in use) should also be stored at room temperature and used within 28 days. A review of Resident #57's May 2021 Medication Administration Record (MAR) revealed she had a current order for 5 units of insulin lispro to be injected subcutaneously three times daily for diabetes (do not give if blood sugar is less than 100). An interview was conducted on 5/26/21 at 11:15 AM with the facility's Director of Nursing (DON). The findings of the Medication Storage task were discussed during the interview. When asked, the DON stated she would expect insulin pens to be initially stored in the refrigerator upon receipt from the pharmacy. She also reported insulin pens should be dated when they were put on the med cart and/or opened. 1-c) In the presence of Nurse #2, an observation was conducted of the 200 Hall Med Cart on 5/24/21 at 3:20 PM. The observation revealed an opened Lantus insulin prefilled pen dispensed for	F 761	medication rooms on each Unit 1 and 2 to identify any expired medications. There were no expired medications found during her audit. This was completed on 06/06/2021. No resident was found to be affected by the deficient practice. In order to ensure that no resident was affected, a continued weekly review of the facility medication carts and treatment carts was conducted by the DON, Unit Support Nurses, and the Weekend RN Supervisor to ensure there were no medications beyond the expiration date and that there were no undated medications in the cart. Corrections were made immediately where indicated. This was completed on 06/21/2021. On 06/14/2021, the DON began educating all full time, part time, agency staff, and PRN Licensed Nurses, Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and Medication Aides on the following topics: " Checking medications for expiration date prior to administering the medication. " Labeling medications when opened with date open as indicated. " McNeill□s Pharmacy recommended storage for selected items. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: On 06/14/2021, the DON began educating all full time, part time, agency staff, and	

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F 761	Continued From page 47 Resident #57 was stored on the med cart. No pharmacy dispensed date was visible on the label of the insulin pen. Nothing was written on the white pharmacy auxiliary sticker placed on the pen which read, "Date Open." When asked, Nurse #2 confirmed no date was written on the insulin pen to indicate when it had been placed on the med cart at room temperature or as to when it had been opened. A review of the manufacturer ' s storage instructions indicated Lantus prefilled pens may be stored at room temperature for 28 days; prefilled pens that have been opened (in use) should also be stored at room temperature and used within 28 days. A review of Resident #57's May 2021 MAR revealed she had a current order for 22 units of Lantus insulin to be injected subcutaneously every night at bedtime. An interview was conducted on 5/26/21 at 11:15 AM with the facility's Director of Nursing (DON). The findings of the Medication Storage task were discussed during the interview. When asked, the DON stated she would expect insulin pens to be initially stored in the refrigerator upon receipt from the pharmacy. She also reported insulin pens should be dated when they were put on the med cart and/or opened. 2) Accompanied by Nurse #1, an observation was made on 5/24/21 at 2:37 PM of the 100/200 Hall Med Room. One stock bottle of 400 mg garlic tablets was identified as being stored with the facility's stock medications. The bottle was unopened and contained 200 tablets. It was labeled with a manufacturer ' s expiration date of	F 761	PRN Licensed Nurses, RNs, LPNs, and Medication Aides on the following topics: " Checking medications for expiration date prior to administering the medication. " Labeling medications when opened with date open as indicated. " McNeill□s Pharmacy recommended storage for selected items. This information has been integrated into the standard orientation training and will be reviewed by the Quality Assurance process to verify that the change has been sustained. As of 5pm on 06/21/2021, any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing or designee will monitor compliance utilizing the F761 Quality Assurance Tool weekly x 4 weeks then monthly x 3 months. The DON or designee will monitor for compliance with labeling medications with a date when opened and ensuring the cart and the medication room is free of expired medications. Reports will be presented to the weekly Quality Assurance committee by the DON to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA	

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F 761	Continued From page 48 May 2020. Upon review of the bottle of garlic tablets, Nurse #1 confirmed it was expired and she was observed as she removed it from the med room. An interview was conducted on 5/26/21 at 11:15 AM with the facility's Director of Nursing (DON). The findings of the Medication Storage task were discussed during the interview. When asked about the expired bottle of garlic tablets found with the facility's stock medications, the DON stated, "that's a problem." She reported the Unit Managers and charge nurses were responsible to ensure no expired medications were stored in either the med carts or the med rooms.	F 761	Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Unit Support Nurses, Health Information Manager, and the Dietary Manager. Date of Compliance: 06/21/2021	
F 809 SS=E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care.	F 809		6/21/21

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F 809	Continued From page 49 This REQUIREMENT is not met as evidenced by: Based on observations, resident, staff and consultant Registered Dietitian (RD) interviews, and record review, the facility failed to obtain resident group approval for greater than 14 hours to elapse between the provision of a substantial evening meal and breakfast the following day for 76 of 78 residents residing at the facility. The findings included: A review of the meal delivery schedule and log, on 5/25/2021 3:32 PM, revealed the earliest scheduled breakfast cart would be prepared at 7:30 - 7:40 AM and the earliest scheduled dinner cart would be 5:00 PM. The time difference between the morning meal to the evening meal was found to be 14.5 hours. The log documented on 5/12/2021 that the earliest evening meal cart was signed as completed at 4:00 PM and on 5/13/2021 the earliest breakfast cart was signed at 7:50 AM. On 5/26/2021 at 10:26 AM an interview was conducted with the Dietary Manager (DM) and she confirmed the meal delivery schedule was 7:30 - 7:40 AM for the earliest breakfast meal cart and 5:00 PM for the earliest evening meal cart. The DM added that the scheduled meal log for the dates of 5/12/2021 and 5/13/2021 were accurate to the best of her knowledge. The DM revealed that the mealtimes had been greater than 14 hours apart since she began employment with the facility a month before. She stated it was her expectation that the meal carts be delivered as scheduled and 4:00 PM was too early. The DM added that she was on vacation 5/12/2021. She added the facility does not schedule substantial	F 809	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F809 1. For dietary services, a corrective action was obtained on 5/24/2021. Upon review of meal times it was noted dietary services failed to discuss or obtain approval from residents for current schedule meal times. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. On 5/24/2021, the Dietary Service Director met with resident council to discuss and obtain approval of schedule meal times. Scheduled meal times were changed to allow for no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime.	

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F 809	Continued From page 50 nourishing snacks at bedtime but stocks snacks in the nourishment room for the nursing assistant staff to pass. The DM denied being aware that Resident council had to approve mealtimes greater than 14 hours apart. On 5/26/2021 at 11:01 AM an interview occurred with the Regional Dietary Consultant/RD and she following day was 14.5 hours. She confirmed the mealtime schedule provided by the DM was the facility schedule for every day. She stated her interpretation of the regulation for mealtime delivery was for no more than 14 hours to lapse between the two meals without resident council approval. She added that resident council had not approved the meal delivery times for the facility because changes had been made during the COVID 19 pandemic and resident council had not met. She added that her expectation would be for the mealtimes to meet the regulatory requirements and not be more than 14 hours apart without resident council approval. On 5/26/2021 at 2:00 pm a Resident Council and the Council meeting was conducted, and they denied being consulted on the meal delivery schedule times. An interview was conducted with the Administrator on 5/27/2021 at 10:02 AM and revealed that he was not aware of a Resident Council approval of the current meal delivery schedule, that the times would be adjusted to meet the regulatory requirements of no more than 14 hours apart and that it was his expectation that meal times be approved by himself and Resident Council.	F 809	3. Systemic changes In-service education was provided to all full time, part time, and as needed staff. Topics included: " Scheduled meal time policies and procedures. " Scheduled meal times must be discussed and approved by residents. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 4. Quality Assurance monitoring procedure. The Dietary Service Director or designee will monitor procedures for scheduled meal time procedures weekly x 2 weeks then monthly x 3 months using the Meal Delivery Schedule Log. Monitoring will include auditing staff for delivery of meals per resident□s preferred scheduled meal times and attending resident council meetings when invited. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information	

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F 809	Continued From page 51	F 809	Manager, and the Dietary Manager	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to discard a container of sloppy joe meat and a box of chicken livers that was outdated and stored in the kitchen freezer available for use in 1 of 1 walk in freezers observed for food storage. The findings included: During the official tour of the kitchen on 5/24/2021 at 9:46 am an observation of the kitchen freezer revealed a large metal container, with precooked sloppy joe meat, covered with plastic wrap, with a	F 812	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F812	6/21/21

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F 812	Continued From page 52 use by date of 3/22/2021. A box of chicken livers, open to the air, was labeled with a date of September 8, 2020 written on the box. An interview was conducted on 5/24/2021 at 10:10 am with the Dietary Manager (DM), who was present during the observation, stated the two food items were labeled prior to her beginning as the DM. She acknowledged the items in the freezer were available for use and needed to be discarded. She discarded the two items immediately. An interview on 5/25/2021 at 11:10 am with the Administrator revealed he would expect for all expired food to be discarded.	F 812	1. For dietary services, a corrective action was obtained on 5/24/2021. During initial walk through of the kitchen, it was noted dietary services had failed to discard outdated bread, label leftover sloppy joe mix, and properly close an opened bag of frozen chicken livers. On 05/24/2021, the Dietary Service Director discarded outdated bread, sloppy joe mix, and chicken livers. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. On 5/24/2021, the Dietary Service Director completed a kitchen walk through to ensure all food items were within their dates and dated properly. 3. Systemic changes In-service education was provided to all full time, part time, and as needed staff. Topics included: " Storage and dating policies and regulations. " Inspections on shifts to observe all food are within their dates and tossed if out of date. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality	

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F 812	Continued From page 53	F 812	Assurance process to verify that the change has been sustained. 4. Quality Assurance monitoring procedure. The Dietary Service Director or designee will monitor procedures for proper food storage weekly x 2 weeks then monthly x 3 months using the Dietary QA Audit which will include inspections on both AM and PM shifts to observe that all food is labeled, dated, and within proper dates. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager	
F 814 SS=F	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to ensure 1 of 1 trash compactors contained disposable waste and ensure the surrounding area was free of standing oil. The findings included:	F 814	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this	6/21/21

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F 814	Continued From page 54 An observation was conducted during a tour of the facility on 05/25/2021 at 10:12 am. A large trash compactor was observed located outside of a side entrance of the kitchen wing of the facility. On the ground, beneath the trash compactor was a thick green black substance which covered the end width of the trash compactor extending to the grease storage container. The ground had numerous cigarette butts littering the area and lying in the black substance. Cigarette butts were also observed inside the top of the grease storage container and around the motor area of the trash compactor. The signage on the grease container had a sign that stated, "Warning flammable". During an interview on 5/24/2021 with the Maintenance Director he stated that the cigarette butts should not be in the area and that the facility was a smoke free campus. He added that one week prior, the motor to the trash compactor had begun to leak oil. He revealed the trash compactor had been repaired but had leaked oil on the ground and pointed to the black substance. He said the cigarette butts lying on the ground in the oil and inside the grease storage container was very concerning to him and should not occur. He then pointed to the warning sign. An interview occurred with the Administrator on 5/25/2021 at 11:10 am and he stated it was his expectation that trash be disposed of properly and not inside of a grease container or on the ground around the dumpster. He pointed to the warning sign on the dumpster and added that the label was clearly defined. He stated that the Maintenance Director will clean the spilled oil on 5/25/2021.	F 814	plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F814 1. For dietary services, a corrective action was obtained on 5/24/2021. During initial dietary inspection, it was noted dietary services had failed to maintain a sanitary outdoor garbage receptacle area by failing to clean cigarettes from the grease vat. Maintenance cleaned grease vat and removed all cigarettes. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. On 5/24/2021, the Dietary Service Director and Maintenance director completed an inspection of the outdoor garbage receptacle area. Grease vat was serviced on 06/11/2021. 3. Systemic changes In-service education was provided to all full time, part time, and as needed staff. Topics included: " Proper garbage disposal and refuse policies and procedures. " Smoking policies and procedures.	

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F 814	Continued From page 55 An observation occurred on 5/27/2021 at 12:04 pm of the trash compactor area and the black substance was no longer on the ground but multiple cigarette butts and plastic cigar mouth pieces were scattered around the trash compactor and grease container.	F 814	This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 4. Quality Assurance monitoring procedure. The Dietary Service Director or designee will monitor procedures for proper garbage disposal and refuse x 2 weeks then monthly x 3 months using the Dietary QA Audit. Monitoring will include inspecting outdoor garbage receptacle area to ensure it is cleaned and maintained per polices. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager	
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.	F 880		6/21/21

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F 880	Continued From page 56 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, 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	F 880		

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F 880	Continued From page 57 disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to follow infection control procedures when 2 of 2 staff members (Nurse Assistants #1 and #2), entered four rooms who were all on enhanced droplet precautions without wearing Personal Protective Equipment (PPE) and did not perform hand hygiene upon exiting the room. The findings Included: A review of the facility's policy entitled COVID-19 Preparation and Response, last revised on 04/29/2021, revealed the policy referenced the Center for Disease Control contact precautions policy which stated, in part, "Wear a gown and gloves for all interactions that may involve contact with the patient or the patient's environment. Donning PPE upon room entry and properly	F 880	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F 880 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #130, #132, #134, and #135	

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F 880	Continued From page 58 discarding before exiting the patient room is done to contain pathogens." An observation was made on 5/24/21 at 12:05 PM of Nurse Assistant #1 entering Resident #130's room on the quarantine hall and delivering the lunch meal tray wearing a surgical mask and eyewear and without putting on a gown or gloves. The resident's door was marked with a black and white enhanced droplet isolation sign stating you must wear eyewear, gown, gloves, and mask when entering room and you must perform hand hygiene when entering and exiting rom. There was not a door hanger containing PPE on the outside of the door. She entered and exited the room without washing her hands and did not use any type of hand sanitizer. She then entered Resident #132's room who was also on enhanced droplet precautions to deliver their meal tray without donning gown or gloves or changing her mask. An interview on 5/24/21 at 12:10 PM with Nurse Assistant #1 revealed that she was aware of the policy regarding wearing eyewear, gloves, and gown when entering an enhanced droplet precaution resident room, but stated she gets in a hurry to take care of the residents and doesn't think about it at times. She stated she was aware of the PPE locations along the hall and had been educated on wearing PPE. An observation was made on 5/24/21 at 12:15 PM of Nurse Assistant #2 in Resident # 134's room on the quarantine hall with an enhanced droplet precaution sign on the door delivering his lunch meal tray wearing a surgical mask and eyewear and without gown or gloves. She exited the room without washing her hands and did not	F 880	were not affected by the deficient practice. The residents all remained on Enhanced Droplet Precautions through the 14th day at which time Isolation precautions were discontinued and there were no complications identified. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: On 06/02/2021, the Staff Nurse completed an audit to review all rooms on the Enhanced Isolation to ensure appropriate isolation signs for Enhanced Droplet Precautions were on the doors of all residents who were currently on Enhanced Droplet Precautions. The result of the review completed by the Staff Nurse revealed that 100% of all resident rooms who were on Enhanced Droplet Precautions had an isolation sign on their door. On 06/02/2021, the Staff Nurse ensured that there was adequate PPE and sanitizer available for staff to utilize on the Isolation Unit. On 06/02/2021, The Staff Nurse audited the Isolation unit to observe staff compliance with adherence to wearing the appropriate personal protective equipment in resident rooms and for appropriate hand hygiene practice when entering and exiting resident rooms. Results revealed less than 100% of compliance with current facility personal protective equipment policy. Any breach in policy was corrected immediately.	

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F 880	Continued From page 59 use any type of hand sanitizer upon exiting into the hallway. She then entered Resident #135's room who was also on enhanced droplet precautions to deliver their meal tray without donning gown or gloves or changing her mask. An interview on 5/24/21 at 12:20 PM with Nurse Assistant #2 revealed she was aware of the policy regarding wearing mask, eyewear, gloves, and gown when entering an enhanced droplet precaution resident room, but stated she gets in a hurry to take care of the residents. She added it was easy to get busy and overlook just the sign especially when the door to the room is open. An interview with the Infection Prevention Nurse/Director of Nursing at 9:50 AM on 5/25/2021 revealed education was provided upon hire and yearly, to all staff regarding infection control practices, policies and procedures including airborne and contact isolation requirements. She stated that all staff members are aware that they need to wear a mask, eyewear, gown, and gloves when entering all the rooms on the quarantine hall. An interview with the Administrator at 9:40 AM on 5/25/2020 revealed he was advised that all staff had been made aware of the facility's enhanced droplet precaution's policy that was revised and updated in April 2021 and that he and the Director of Nursing were in the process of reviewing current practices and re-educating all staff on the importance of following the policy.	F 880	3. Address what measures will be put in place or systematic changes made to ensure that the deficient practice will not reoccur: Education: On 06/02/2021, the Director of Nurses (DON) and the Clinical Nurse Consultant who are both Infection Preventionist initiated education for all full time, part time, PRN staff, and agency staff on the CDC□s How to Safely Put on Personal Protective Equipment (PPE), How to Safely Take Off PPE, and Hand Hygiene. This information has been integrated into the standard orientation training and will be reviewed by the Quality Assurance process to verify that the change has been sustained. As of 5pm on 06/25/2021, any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed Root Cause Analysis: A Root Cause Analysis was initiated on 06/18/2021 to discuss the root cause analysis of this event. The team members participating in the Root Cause Analysis included the following staff members: Administrator, Director of Nurses, Unit Support Nurse, Licensed Practical Nurse, Certified Nursing Assistant, and the Medical Director. On 6/21/2021 a follow up root cause analysis meeting was held to discuss ongoing	

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F 880	Continued From page 60	F 880	solutions to address the root cause. The follow up root cause analysis meeting was attended by the Administrator, DON, Minimum Data Set Nurse, Health Information Manager, Business Office Manager, and the Clinical Nurse Consultant all of who are members of the facility Quality Assurance and Performance Committee. This Root Cause Analysis will be a part of our ongoing Performance Improvement Process. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements: The Director of Nursing or designee will monitor compliance utilizing the F880 Quality Assurance Tool weekly x 4 weeks then monthly x 3 months. The DON or designee will monitor for compliance with wearing appropriate PPE (to include donning/doffing of PPE) and hand hygiene practices. Reports will be presented to the weekly Quality Assurance committee by the DON to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Nurse, Therapy Manager, Unit Support Nurses, Health Information Manager, and the Dietary Manager.	

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F 880	Continued From page 61	F 880	Directed Plan of Correction Compliance Date: 06/25/2021 Compliance Date: 06/25/2021	