

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345179	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/25/2021
NAME OF PROVIDER OR SUPPLIER ACCORDIUS HEALTH AT MOORESVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 752 E CENTER AVENUE MOORESVILLE, NC 28115	
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E 000	Initial Comments	E 000		
F 000	An unannounced Recertification and Complaint Investigation survey was conducted on 06/21/21 through 06/25/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #M7AW11. INITIAL COMMENTS	F 000		
F 550 SS=G	A recertification and complaint investigation survey was conducted from 06/21/21 through 06/25/21. Event ID# M7AW11. 15 of the 23 allegations were substantiated resulting in deficiencies. Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550		7/26/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

07/22/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 550	<p>Continued From page 1</p> <p>§483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.</p> <p>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, and staff interview the facility failed to treat Resident #40 in a dignified manner when she turned her call light on for assistance and three staff members entered her room without asking Resident #40 what she needed and turned her call light off without meeting Resident #40's need which made her feel sad and worthless like the staff did not care about her or her needs. The facility also failed to treat Resident #15 in a dignified manner when a Cook at the facility spoke loudly to Resident #15. This affected 2 of 4 residents reviewed for dignity.</p> <p>The findings included:</p> <p>1. Resident #40 was admitted to the facility on 5/01/20 with diagnoses that included diabetes, cerebral vascular accident (CVA), chronic kidney disease, and congestive heart failure (CHF).</p>	F 550	<p>#1 On 7/1/21 the Director of Nursing (DON) or Designee provided 1:1 education to Nurse Aide (NA) #2 and Laundry Worker (LW) #1 for Resident #40's right to dignity and answering call lights in a timely and respectful manner. Resident #40 will continue to be treated with dignity and respect while residing at the facility. Cook #1 was terminated on 6/29/21.</p> <p>#2 On 6/29/21, Department Heads completed an audit of interviewable residents via resident questionnaire to ensure residents are treated with dignity and respect. If identified, concerns are addressed per the facility grievance process.</p> <p>#3 The DON provided education to direct and indirect staff on the residents right to dignity while residing in the facility and the</p>		

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F 550	<p>Continued From page 2</p> <p>The annual Minimum Data Set (MDS) dated 05/09/21 revealed Resident #40 was cognitively intact with the ability to make her needs known and needed extensive to total care for her activities of daily living (ADL) to include transfers, bed mobility, and toileting. It further indicated Resident #40 was always incontinent of bowel and bladder and had no behavioral issues such as rejection of care.</p> <p>Resident #40 had a fall care plan dated 05/14/20 which indicated she was to have her call light in reach at all times and encouraged her to use it.</p> <p>A continuous observation and interview with Resident #40 on 06/21/21 beginning at 3:23 PM and ending at 4:00 PM in Resident #40's room revealed she was sitting up in her wheelchair facing the bed with the call light on. The signage on the door indicated Resident #40 was on Enhanced Droplet Isolation Precautions. Resident #40 mentioned she had her call light on to request assistance from staff and she felt staff were reluctant to answer her call light because they had to "garb up" (don full personal protective equipment-PPE) just to provide her pain medications or assist her to the toilet. Resident #40 continued to say staff did not answer her call light recently when she slid from her wheelchair and another resident went to obtain help after she had hollered for a while. She stated when there were substantial delays in answering her call light almost daily and staff not addressing her needs when they did enter her room, it made her feel sad, worthless, and as though staff did not care about her or what her needs were. Resident #40 mentioned she had complained in the past (although she could not recall an exact date) to</p>	F 550	<p>timely, respectful response to call lights by 7/26/21. Call lights will be answered upon finding by direct and indirect care staff in a timely and respectful manner. Call lights will remain illuminated until the resident needs are met by the appropriate staff member. Newly hired direct and indirect care staff will receive education during orientation.</p> <p>#4 The Social Worker or Designee will complete an audit for ten (10) random interviewable residents via resident questionnaire to ensure resident right to dignity and respect is exercised and call lights answered timely. Monitoring will be completed five (5) times weekly for four (4) weeks, then weekly for eight (8) weeks and as necessary thereafter. The Administrator will report findings of the monitoring to the Interdisciplinary Team (IDT) during QAPI meetings monthly for three (3) months and will make changes to the plan as necessary to maintain compliance with resident rights to respect and dignity.</p>		

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F 550	<p>Continued From page 3</p> <p>the former Director of Nursing about staff not answering lights timely and was told they would monitor this, but while being on the quarantine unit it was taking longer again. At approximately 3:35 PM, the facility Administrator opened the door without knocking and looked in the room and made eye contact with the surveyor in the room, did not address Resident #40's needs, and turned and shut the door. Shortly following that at 3:47 PM, Laundry Worker (LW) #1 and Nurse Aide (NA) #2 entered the room to return a mesh bag of laundry belonging to Resident #40. NA #2 then turned off Resident #40's call light without asking how she could address her needs and turned and left the room with LW #1. During the 37- minute continuous observation, Resident #40's needs were not addressed by a staff member.</p> <p>An interview on 06/21/21 at 4:05 PM with NA #2 revealed she was assigned to work with Resident #40 on that shift. She acknowledged she had entered the room to return the laundry provided by LW #1 and had turned the call light off without thinking about asking what Resident #40 may have needed. NA #2 indicated she was aware she had sustained multiple falls and was a high fall risk and required assistance with her ADL. NA #2 stated she had been taught to answer all call lights timely and address the request of the resident. She indicated she was not to turn off the call light unless she was able to address the need of the resident, but all staff were to answer resident call lights. NA #2 stated she would try to do a better job in addressing her needs timely.</p> <p>An interview on 06/24/21 at 2:00 PM with the Director of Nursing (DON) revealed all staff had been trained to answer and address call lights</p>	F 550			

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F 550	<p>Continued From page 4</p> <p>timely. She acknowledged Resident #40's call light should have been addressed before she waited over 30 minutes with the light on and NA #2 should not have turned the call light off without helping Resident #40. The DON was unaware Resident #40 felt as though staff did not care about her or her needs, but indicated it was unacceptable to not assist a resident or get the appropriate person to help before turning a call light off.</p> <p>An interview on 06/25/21 at 2:46 PM with the Administrator revealed he did not recall opening the door to Resident #40's room without knocking or addressing her needs on 06/21/21. He elaborated he expected all staff to address call lights timely and treat all residents with dignity and respect.</p> <p>2. Resident #15 was readmitted to the facility on 10/17/20 with diagnoses that included diabetes, heart failure, osteoarthritis, and others.</p> <p>Review of a comprehensive Minimum Data Set (MDS) dated 04/09/21 revealed that Resident #15 was cognitively intact for daily decision making and required extensive assistance with activities of daily living.</p> <p>An interview was conducted with Resident #15 on 06/21/21 at 12:50 PM. Resident #15 stated that on April 05, 2021 Cook #1 was in the hallway and she stated to him that he had prepared a salad a few days prior that was not acceptable. Resident #15 explained that it was a chef salad that did not have any meat on it and the lettuce was wilted. She stated that Cook #1 began to speak very loudly and rudely and began to argue with her</p>	F 550			

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F 550	<p>Continued From page 5</p> <p>and stated that she was the reason he was going to quit. Resident #15 also stated that Cook #1 stated that he was not going to do anything else to accommodate Resident #15 before leaving the hallway directly in front of her room. She added that the Director of Nursing (DON) was in her office next door to Resident #15 and overheard the verbal exchange. Resident #15 stated that she was fearful of eating anything he served and when he was cooking, she generally would order outside food.</p> <p>An interview was conducted with Cook #1 on 06/23/21 at 12:15 PM. Cook #1 stated that a few days prior to April 05, 2021 he was preparing salads for the evening meal and was running low on salad mix and had to split it up between all the residents that ordered salads that night. Cook #1 stated that Resident #15 "got the skimpy one" and was not up to Resident #15's standards. Cook #1 continued to say that on April 05, 2021 he was in the hallway and Resident #15 began to complain about her salad that she received a few days prior and he took it very personal and "raised my voice" with Resident #15. Cook #1 stated that he could not recall the exact words that were used but stated there were no curse words but the way he spoke to Resident #15 was inappropriate. He added that he prepared Resident #15's meal just as he did all the other residents and he had taken it personal that she did not enjoy the salad he had prepared for her despite it being "skimpy."</p> <p>An interview was conducted with the DON on 06/24/21 at 3:06 PM. The DON stated that on April 05, 2021 she was in her office with the door open which was next door to Resident #15's room. The DON stated that she heard Cook #1</p>	F 550			

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F 550	Continued From page 6 very loudly say, "I am not going to do anything extra for you anymore." The DON stated that it shocked her because no staff member should be that loud in the hallway while speaking to a resident. The DON stated she got up and went to the hallway and Cook #1 had already reached the nurses station and was on his way back to the kitchen. She stated she went into Resident #15's room and she was very upset and stated that she did not want Cook #1 preparing her meals anymore. The DON stated she never spoke to Cook #1 about the incident but did report it to the previous Administrator. The DON stated she did not want the staff speaking to the residents in the manner and tone that Cook #1 spoke to Resident #15 in on that day. An interview was conducted with the Administrator on 06/25/21 at 2:46 PM. The Administrator stated that he expected the staff to treat the resident with respect and dignity and it was not appropriate to speak to Resident #15 in a loud/rude tone.	F 550			
F 554 SS=E	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff and residents' interviews, the facility failed to assess Residents' #45, #30, #20's ability to self administer medications left at the residents' bedside. This was for 3 of 3 residents reviewed for self administration of medications.	F 554	F554 Resident Self-Admin Meds-Clinically Approp (S/S-E) #1 The licensed nurse completed an assessment for self-administration of medication, obtained a physician order	7/26/21	

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F 554	<p>Continued From page 7</p> <p>The findings include:</p> <p>1. Resident #45 was admitted to the facility on 05/11/21 with diagnoses that included lung cancer and chronic obstructive pulmonary disease.</p> <p>The admission Minimum Data Set assessment dated 05/18/21 indicated Resident #45 was cognitively intact.</p> <p>On 06/21/21 at 4:51 PM an interview and observation were made of Resident #45 in her room with a necklace around her neck that had an unlabeled inhaler stored in a pouch connected to the necklace. The Resident explained that she used the rescue inhaler when she became short of breath. The inhaler had an expiration date of 12/2021.</p> <p>A review of Resident #45's physician orders on 06/21/21 revealed no order for the inhaler or for medications to be left at bedside.</p> <p>A review of Resident #45's care plan on 06/21/21 revealed no care plan for self administration of medications.</p> <p>A review of Resident #45's medical record on 06/21/21 revealed no self administration of medication assessment.</p> <p>An interview was conducted with the Medication Aide (MA) #1 on 06/23/21 at 3:40 PM. The MA explained that she did not know that Resident #45 had an inhaler that she kept at her bedside until she discovered it on 06/21/21 and reported it to the Director of Nursing. The MA stated she did not know what the system was for the residents</p>	F 554	<p>and updated the plan of care for Resident #45, #30 and #20 to self-administer their inhaler and maintain at bedside by 7/26/21. Residents will be reassessed for continued ability to safely self-administer medication quarterly and with changes in resident condition.</p> <p>#2 the DON and Unit Managers completed an audit of residents who self-administer medications by 7/26/21. A completed assessment, care plan and physician order implemented as appropriate.</p> <p>#3 The DON and/or Designee provided education to licensed nurses and medication aides on the assessment, care planning and order requirements for residents who self-administer medications by 7/26/21. Self-administration of medication assessments will be completed initially, quarterly and with changed in resident condition for residents who self-administer medications. Newly hired licensed nurses and medication aides will receive education during orientation.</p> <p>#4 The DON and/or Designee will complete quality assurance monitoring for all residents to ensure medications are not present at bedside without appropriate assessment, care plan and orders. Monitoring will be completed five (5) times weekly for four (4) weeks, then weekly for eight (8) weeks and as necessary thereafter. The Administrator will report findings of the monitoring to the IDT</p>		

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F 554	<p>Continued From page 8</p> <p>to keep their medications in their rooms.</p> <p>An interview was conducted with the Nurse Practitioner (NP) on 06/25/21 at 9:30 AM. The NP stated that if medications were kept at bedside he would expect the staff to assess the resident and ensure that they were able to safely administer their medications independently.</p> <p>An interview was conducted with the Director of Nursing (DON) on 06/25/21 at 10:17 AM. The DON explained that if a resident requested to keep medications at bedside then they would need a physician order and a self administration of medication assessment to indicate that the resident was able to keep the medication at their bedside and then the medication would need to be securely stored at bedside. The DON stated she would expect the staff to follow the facility policy when allowing the residents to self administer medications and that included having the physician order and the self administration assessment of medications.</p> <p>During an interview conducted with the Administrator on 06/25/21 at 3:40 PM he stated that he expected residents that kept medications at bedside did so according to their self administration of medication assessment as directed by the facility policy.</p> <p>2. Resident #30 was admitted to the facility on 04/07/21 with diagnoses that included lung cancer.</p> <p>A review of Resident #30's physician orders dated 04/21/21 revealed an order for Albuterol Sulfate HFA 180 (90 based) MCG (micrograms) inhaler 2 puffs orally every 2 hours as needed for</p>	F 554	during QAPI meetings monthly for three (3) months and will make changes to the plan as necessary to maintain compliance with residents self-administration of medications.		

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F 554	<p>Continued From page 9 shortness of breath, may keep at bedside.</p> <p>The significant change Minimum Data Set assessment dated 04/29/21 indicated Resident #30 had moderately intact cognition.</p> <p>A review of Resident #30's care plan on 06/21/21 revealed no care plan for self administration of medications.</p> <p>A review of Resident #30's medical record on 06/21/21 revealed no self administration of medication assessment.</p> <p>On 06/21/21 at 11:40 AM an interview and observation were made of Resident #30 in his room. The Resident explained that he had lung cancer and required a "rescue inhaler" at times which he kept on his bedside table. An observation of an unlabeled Albuterol inhaler with 40 puffs left and the expiration date of 06/2022 was in a clear plastic cup on top of the bedside table. Resident #30 continued to explain that he used the inhaler when he was short of breath about twice a day and some days he did not use it at all.</p> <p>An interview was conducted with the Medication Aide (MA) #1 on 06/23/21 at 3:40 PM. The MA explained that Resident #30 was allowed to keep his inhaler at his bedside because he could administer the inhaler himself. The MA stated she did not know what the system was for the residents to keep their medications in their rooms.</p> <p>An interview was conducted with the Nurse Practitioner (NP) on 06/25/21 at 9:30 AM. The NP stated that if medications were kept at bedside he</p>	F 554			

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F 554	<p>Continued From page 10</p> <p>would expect the staff to assess the resident and ensure that they were able to safely administer their medications independently.</p> <p>An interview was conducted with the Director of Nursing (DON) on 06/25/21 at 10:17 AM. The DON explained that if a resident requested to keep medications at bedside then we would need a physician order and a self administration of medication assessment to indicate that the resident was able to keep the medication at their bedside and then the medication would need to be securely stored at bedside. The DON stated she would expect the staff to follow the facility policy when allowing the residents to self administer medications and that included having the physician order and the self administration assessment of medications.</p> <p>During an interview conducted with the Administrator on 06/25/21 at 3:40 PM he stated that he expected residents that kept medications at bedside did so according to their self administration of medication assessment as directed by the facility policy.</p> <p>3. Resident #20 was admitted to the facility on 04/08/21 with diagnoses that included chronic obstructive pulmonary disease and disorder of the lung.</p> <p>Review of the comprehensive Minimum Data Set (MDS) dated 04/15/21 revealed that Resident #20 was cognitively intact for daily decision making</p>	F 554			

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F 554	<p>Continued From page 11 and required limited assistance with activities of daily living.</p> <p>Review of a physician order dated 06/16/21 read, Fluticasone-Salmeterol 250/50 micrograms (mcg) aerosol powder breath activated 1 puff by mouth twice a day for chronic obstructive pulmonary disease. May leave at bedside.</p> <p>An interview and observation of Resident #20 were conducted on 06/21/21 at 10:45 AM. Resident #20 indicated that he kept his inhaler in his top drawer of his night stand so he could take it when he was supposed to take it which was twice a day. An observation of Resident ##20's first drawer of his nightstand the drawer was noted to be unlocked and his Fluticasone-Salmeterol 250/50 mcg was in the top drawer.</p> <p>Review of Resident #20's care plan on 06/21/21 revealed no care plan for self-administration of medications.</p> <p>Review of Resident #20's medical record on 06/21/21 revealed no self-administration of medication assessment.</p> <p>An interview was conducted with the Unit Manager (UM) on 06/24/21 at 10:24 AM. The UM stated that if a resident requested to keep medications at bedside, they would first ask the physician if it was ok and write the order. The UM stated after the order was obtained, we would assess the resident. The UM stated that she had assessed Resident #20 on 06/23/21 which was the first the person she has ever had to do the self-administration of medication assessment on. The UM stated that the assessment lead us to</p>	F 554			

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F 554	<p>Continued From page 12</p> <p>make sure the medication was secured at bedside. The UM stated that at times Resident #20 would use the inhaler and leave it on his bedside table and then after the evening dose would put it back into the top drawer of his nightstand.</p> <p>A follow up observation and interview were conducted with Resident #20 on 06/24/21 10:37 AM. Resident #20 state that the staff had come in yesterday and asked me why he had his inhaler at bedside, and I told them. He stated that he knew the inhaler was supposed to be used twice a day.</p> <p>An interview was conducted with the Nurse Practitioner (NP) on 06/25/21 at 9:30 AM. The NP stated that if medications were kept at bedside, he would expect the staff to assess the resident and ensure that they were able to safely administer medications independently.</p> <p>An interview was conducted with the Director of Nursing (DON) on 06/25/21 at 10:17 AM. The DON stated that if a resident requested to keep medications at bedside we would need an physician order and an assessment indicating that resident was able to keep them at bedside and then the medication would need to be securely stored at bedside. The DON she would expect for the staff to follow the facility policy when allowing residents to self-administer and store medications at bedside and that included having the physician order and the self-administration of medication assessment.</p> <p>An interview was conducted with the Administrator on 06/25/21 at 3:40 PM. The Administrator stated that he expected residents</p>	F 554			

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F 554	Continued From page 13 that kept medications at bedside did so according to their assessment as directed by the facility policy.	F 554			
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and resident interviews the facility failed to provide access to the call light system for 1 of 58 residents (Resident #33) reviewed for accommodation of needs and failed to provide the appropriate sized incontinent product for 1 of 10 dependent residents (Resident #7) reviewed for activities of daily living. The finding included: Resident #33 was admitted to the facility on 04/29/21 with diagnoses that included cerebral vascular accident (CVA). The admission Minimum Data Set (MDS) assessment dated 05/06/21 revealed Resident #33's cognition was moderately impaired and required supervision assistance of one staff for all her activities of daily living. The MDS also indicated Resident #33's balance was not steady, and she was occasionally incontinent of bladder. A review of Resident #33's care plan dated	F 558	#1 Resident #33's call bell continues to be securely attached to bed linen within reach to ensure easy accessibility and accommodation of needs. Resident #7 continue to receive appropriate brief for her incontinence needs. #2 On 6/25/21 the Maintenance Director completed an audit of resident call bells to ensure proper placement for easy accessibility and accommodation of needs. The Unit Manager completed an audit of incontinent residents to ensure proper fitting briefs are provided and available by 7/26/21. #3 DON or Designee provided education to nursing on monitoring and maintaining call bells for secure, easily accessible placement and providing proper fitting incontinence products to meet resident needs by 7/26/21. Regional Director of Operations provided education to Maintenance Director on monitoring and maintaining call bells in resident rooms by 7/26/21. the Administrator provided	7/26/21	

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F 558	<p>Continued From page 14</p> <p>05/12/21 revealed she was at risk for falls related to a recent CVA with the goal that she would be free from falls through the next review date. The interventions utilized to obtain the goal included: ensuring the call light was within reach and encourage Resident #33 to use it as well as having a workable and reachable call light.</p> <p>On 06/23/21 at 2:25 PM an observation and interview with Resident #33 was conducted. The observation revealed there was no call light cord available for the Resident to ring for staff assistance. The Resident stated she did not have a call light cord and when she needed something she had to walk to the door and get someone's attention. The Resident's roommate Resident #45 who was cognitively intact explained she and Resident #33 moved into the room on the same day and Resident #33 has had no call light cord attached to her call light since that day.</p> <p>An observation on 06/24/21 at 2:30 PM revealed there was no call light cord attached to Resident #33's call light to ring for assistance.</p> <p>An observation on 06/25/21 at 8:35 AM revealed there was no call light cord attached to Resident #33's call light to ring for assistance.</p> <p>A review of the "Nurse Call System" call light audit provided by the facility conducted 06/15/21 and completed by the Maintenance Assistant indicated 100 Hall passed inspection.</p> <p>On 06/25/21 at 9:06 AM an interview was conducted with the Maintenance Supervisor (MS) who explained that he made walking rounds throughout the facility about twice a week to identify issues that needed to be addressed by</p>	F 558	<p>education to the Central Supply Clerk on ordering and maintaining an adequate supply inventory of incontinence products in various sizes as determined by resident needs. Newly hired staff will receive education during orientation.</p> <p>#4 The Maintenance Director or Designee will complete quality assurance monitoring by observing ten (10) random resident rooms for proper placement of call bells to ensure accessibility. The DON and/or Unit Manager will complete monitoring of (5) incontinent residents for proper fit and availability of incontinence products. Monitoring will be completed five (5) times weekly for four (4) weeks, then weekly for eight (8) weeks and as necessary thereafter. The Administrator will report findings of the monitoring to the IDT during QAPI meetings monthly for three (3) months and will make changes to the plan as necessary to maintain compliance with residents right to reasonable accommodations of needs.</p>		

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F 558	<p>Continued From page 15</p> <p>the maintenance department. The MS continued to explain that when staff other than the maintenance department discovered issues that needed to be addressed, they would either verbally relay the concern to him or fill out a request through the computer system for maintenance repairs. The MS explained that he had one assistant for the maintenance department who was responsible for conducting the call light audit which was completed two weeks ago. He stated he was not aware of a concern regarding Resident #33's call light cord.</p> <p>Attempts were made to interview the Maintenance Assistant but were unsuccessful.</p> <p>During an interview with the Administrator on 06/25/21 at 11:28 AM he expressed that he was unaware that Resident #33 did not have a call light available to her and that it was unacceptable. The Administrator stated that the missing call light cord should have been identified on maintenance rounds during the last audit.</p> <p>2. Resident #7 was admitted to the facility on 03/09/21 with diagnoses that included diabetes.</p> <p>A self-care deficit care plan dated 03/22/21 revealed Resident #7 was dependent for bed mobility, dressing, toileting, hygiene, and bathing and required 1-2 staff assistance.</p> <p>A bowel and bladder care plan dated 3/22/21 indicated Resident #7 was incontinent of bowel and bladder with interventions to clean peri-area with each incontinent episode.</p> <p>A recent quarterly Minimum Data Set dated 06/16/21 revealed Resident #7 was rarely or</p>	F 558			

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F 558	<p>Continued From page 16</p> <p>never understood and extensive to total dependent for all ADL care. The MDS further indicated Resident #7 was always incontinent of bowel and bladder.</p> <p>An observation of wound care provided by Nurse #8 on 06/24/21 at 3:20 PM revealed Resident #7 in bed. Nurse #8 entered the room to perform wound care therapy to her Stage II pressure ulcer to her sacrum. Nurse #8 pulled back the sheet that was partially draped over Resident #7 and realized Resident #7 needed incontinence care because her blue brief was soiled. Nurse #8 was unable to locate a brief in Resident #7's room and exited the room and returned with a white brief which she wrapped around Resident #7 twice due to the brief being oversized, then covered Resident #7 with her sheet.</p> <p>An interview on 06/24/21 at 3:38 PM with Nurse #8 revealed she had entered the room to perform pressure ulcer care she found Resident #7 in need of incontinence care. Nurse #8 stated when she was unable to locate a brief for Resident #7 in her room, she quickly exited the room and retrieved the first available brief instead of a smaller brief for time sake. Nurse #8 stated the facility did not have a brief to fit Resident #7 due to her size and therefore they typically used the smallest brief the facility carried which was a small. She believed the brief applied on 06/24/21 to be a medium or large.</p> <p>An interview on 06/24/21 at 4:36 PM with the Director of Nursing revealed she the appropriately sized brief applied each time. She stated she was aware the facility had not previously had the ability to order a pediatric sized brief until they had switched to a different incontinence product</p>	F 558			

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F 558	Continued From page 17	F 558			
F 561 SS=D	<p>company and the DON explained she would be requesting the pediatric size be ordered in the future for Resident #7.</p> <p>Self-Determination CFR(s): 483.10(f)(1)-(3)(8)</p> <p>§483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f) (1) through (11) of this section.</p> <p>§483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.</p> <p>§483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>§483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.</p> <p>§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on staff and Resident interviews, the facility failed to honor Resident #13's choice of</p>	F 561	#1 Resident #13 to continue to get out of bed per preference.	7/26/21	

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F 561	<p>Continued From page 18</p> <p>getting out of bed every day for 1 of 7 residents reviewed for choices.</p> <p>The finding included:</p> <p>Resident #13 was admitted to the facility on 04/24/17 with diagnoses that included seizure disorder and arthritis.</p> <p>The annual Minimum Data Set (MDS) assessment dated 04/06/21 revealed Resident #13 was cognitively intact and was totally dependent with two person assistance from staff for transfers and required extensive assistance from two staff for dressing. The MDS also indicated Resident #13 was incontinent of bladder and bowel.</p> <p>The care plan for Resident #13 dated 07/16/20 addressed a self care deficit performance related to impaired mobility and arthritis. The goal to maintain the ability to feed herself through the next review would be attained by interventions that included offering Resident #13 to lay down after lunch for rest periods and to transfer with mechanical lift with two staff assist.</p> <p>A review of Resident #13's Kardex (a care guide for staff) dated 06/23/21 indicated to offer to lay down after lunch for rest periods.</p> <p>On 06/23/21 at 3:55 PM Resident #13 explained that she desired to get out of bed every day after breakfast and laid down before second shift began. The Resident continued to explain that she was not gotten out of bed the past weekend of 06/19/21-06/20/21 because there was only one nurse aide assigned to the hall and it took two people to get her up due to her need to be gotten</p>	F 561	<p>#2 On 6/29/21 the Department Heads completed an audit of interviewable residents via resident questionnaire to ensure residents are getting out of bed per preference. If identified, concerns are addressed per the facility grievance process.</p> <p>#3 Nurse and CNA assignments will be reviewed and adjusted as necessary to better meet the needs of each resident. Shower Schedule grid was updated with resident preferences on 7/15/21. DON and/or Unit Manager to verify ADL care performed appropriately and assignment sheet followed. Manager on Duty, implemented on 7/24/21, will ensure showers, ADL care, out of bed preferences, call bells answered timely, are occurring on weekends via rounding, and resident interviews. CNA and Nursing schedules were changed on 6/27/21 to better meet the needs of the residents. Department Heads round five (5) per week to ensure resident grievances are addressed and resolved, showers received per their preference, call bells answered timely, and incontinence care given as needed. Newly hired direct staff will receive education by 7/26/21 and during orientation.</p> <p>#4 Administrator will report findings from monitoring to the IDT (Interdisciplinary Team) during QAPI meetings monthly for 3 months and will make changes to the plan as necessary to maintain compliance with resident's Self Determination.</p>		

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F 561	<p>Continued From page 19</p> <p>up with a mechanical lift. Resident #13 stated Nurse Aide #5 worked on 06/19/21 and Nurse Aide #1 worked on 06/20/21 and they had the whole hall to do by themselves. The Resident explained it made her sad to lay in the bed 24 hours a day because she liked to be up out of bed and able to read her Bible and she could not do that when she was in the bed.</p> <p>An interview was conducted with Nurse Aide (NA) #5 on 06/24/21 at 1:31 PM. The NA confirmed that she worked by herself on Resident #13's hall on 06/19/21 and did not get the Resident out of bed that day because the Resident was a two person assist for dressing and transfers and she did not have anyone to help her get Resident #13 out of bed. The NA stated that Resident #13 was mad and stated she understood but that she was just tired of staying in bed all day.</p> <p>Attempts were made to interview Nurse Aide #1 who worked on Resident #13's hall on 06/20/21 but were unsuccessful.</p> <p>On 06/24/21 at 5:44 PM an interview was conducted with Nurse Aide #6 who confirmed he worked on day shift on 06/20/21. The NA explained he helped NA #1 with incontinent care for Resident #13 on that day and verified that the Resident did not get out of bed during the shift due to short staffing.</p> <p>An interview was conducted with the Director of Nursing (DON) on 06/25/21 at 10:08 AM. The DON stated that she expected the staff to honor the Resident's preference of getting out of bed every day even on the weekends.</p> <p>During an interview with the Administrator on</p>	F 561			

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F 561	Continued From page 20 06/25/21 at 11:30 AM he indicated that it was not an unreasonable request for Resident #13 to be gotten out of bed every day if that was what she desired.	F 561			
F 567 SS=D	Protection/Management of Personal Funds CFR(s): 483.10(f)(10)(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(10)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of \$100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed \$100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of	F 567		7/26/21	

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F 567	<p>Continued From page 21</p> <p>the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed \$50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by:</p> <p>Based on resident and staff interviews, and record reviews, the facility failed to ensure residents had access to their personal funds held by the facility in Resident Trust Fund Accounts after the facility's banking hours for 2 of 2 residents reviewed for personal funds (Resident #40 and Resident #15).</p> <p>Findings included:</p> <p>1. Resident #40 was admitted to the facility on 5/01/20.</p> <p>A recent Annual Minimum Data Set (MDS) dated 05/09/21 revealed Resident #40 was cognitively intact and able to make her needs known.</p> <p>An observation and interview with Resident #40 on 06/21/21 at 3:33 PM revealed she currently resided on the observation quarantine unit and was under Enhanced Droplet Precautions. Resident #40 stated she had requested money from her Resident Trust Fund account, but she had not received it. She stated the Social Worker never returned with the requested funds. Resident #40 explained she did not have a lot of money, but I would like to be able to get what little I have when I need it without having to wait or beg for it. Resident #40 indicated she had asked a nursing assistant on the evening shift to check on</p>	F 567	<p>#1 Resident #40 and #15 personal funds were made available to them per their request and continue to made available as requested.</p> <p>#2 On 7/1/21 Resident council attendees voted on banking hours and educated on personal funds policy.</p> <p>#3 Business Office Manager educated receptionists and nurse managers on Availability of Resident Funds After Business Office Hours and banking hours by 7/26/21. Regular banking hours are Monday-Friday 9am-5pm and Saturday 9am-12pm. After hours funds will be available by charge nurse on 200 hall for requests via the petty cash box kept in med room. Cash box will be reconciled by Business Office Manager, Receptionist, etc with the 200 hall charge nurse. Newly hired staff will receive education by 7/26/21 and during orientation.</p> <p>#4 Business Office Manager will complete quality assurance monitoring by interviewing five (5) random residents for funds availability. Monitoring will be completed five (5) times weekly for four (4) weeks, then weekly for eight (8) weeks and as necessary thereafter. The Administrator will report findings of the monitoring to the IDT during QAPI</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345179	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/25/2021
NAME OF PROVIDER OR SUPPLIER ACCORDIUS HEALTH AT MOORESVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 752 E CENTER AVENUE MOORESVILLE, NC 28115		
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F 567	<p>Continued From page 22</p> <p>getting her money and was told the office was closed and she would have to check back during the daytime. Resident #40 was unable to identify the staff member working on the evening shift during the interview.</p> <p>An interview on 06/22/21 at 2:22 PM with Social Worker #1 revealed she was familiar with Resident #40 requesting money once from her trust fund account, but she did not recall the date and was unaware if Resident #40 received the requested funds after the request had been made. The SW stated she had provided Resident #40 a lock to ensure her money would be secured in her room, but she no longer was employed by the facility and did not have access to dates of contact with Resident #40.</p> <p>An interview on 06/25/21 at 9:11 AM with the Business Office Manager (BOM) revealed she worked primarily during standard banking hours and occasionally she worked as a receptionist from 3-8 PM on a weekend evening. The BOM stated any money the facility received for a resident was deposited into a resident trust fund type account and each resident and/or their responsible party received a billing statement to notify them of the amount of money available. She indicated each resident was allowed to withdraw money from that account and a record was logged into the accounting software to ensure accuracy and up-to-date balances. The BOM explained residents do not currently have access to funds at all times due to the facility not having a consistent staff member on duty at all times and she does not feel the accounts would be safe if agency staff were allowed to access the funds when the business office was closed or off duty. The BOM elaborated to include the Medical</p>	F 567	meetings monthly for three (3) months and will make changes to the plan as necessary to maintain compliance with personal funds.		

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F 567	<p>Continued From page 23</p> <p>Records Coordinator (MRC) had been trained to access the funds for residents when she worked as the receptionist for part of the shift on a weekend, but admitted that the MRC did not work every weekend or all shift on both Saturday and Sunday consistently. She further indicated there was no available access at any time during the hours of 8 PM and 7 AM.</p> <p>An interview on 06/25/21 at 3:22 PM with the MRC revealed she had been trained as a back-up to the BOM to access resident funds accounts and provide money directly to the resident upon request. She indicated the primary duty belonged to the BOM and funds were usually available from 10 AM to 5 PM Monday through Friday, but she assisted when she was on duty as the receptionist part of the shift on Saturdays from 3-8 PM. The MRC explained most of the residents who had monies available in the trust fund accounts were unable to leave the facility to cash a check, but if a resident requested more than their allowable \$30 per day, particularly on the weekend, then, they must notify the business office ahead of time and she would write them a check and they must have their family take them to the bank to cash the check. She revealed the facility did not have enough funds on hand to offer more than the \$30 per day for a limited number of residents and a check was the only available form. The MRC further elaborated to say she knew of 5 residents who routinely "hit her up" on Fridays for money so they could use their monies to order takeout over the weekend. She could not recall if Resident #40 had requested money from her account.</p> <p>An interview on 06/25/21 at 3:34 with the Administrator revealed residents typically did not</p>	F 567			

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F 567	<p>Continued From page 24</p> <p>have access to their funds on the weekends with the exception of when the MRC worked as the receptionist occasionally. He indicated he had requested the facility's resident counsel to discuss the concern, but he had not followed up on the issue. The Administrator stated he expected the residents were allowed to have access to their money at all times even on evenings and weekends.</p> <p>2. Resident #15 was readmitted to the facility on 10/17/20 with diagnoses that included diabetes, heart failure, osteoarthritis, and gout.</p> <p>Review of the comprehensive Minimum Data Set (MDS) dated 04/09/21 indicated that Resident #15 was cognitively intact for daily decision making and required extensive assistance with activities of daily living.</p> <p>A tour of the facility was conducted on 06/21/21 and banking hours were not observed to be posted in the facility.</p> <p>An interview was conducted with Resident #15 on 06/21/21 at 12:50 PM. Resident #15 stated that she ordered food a lot and had it delivered to the facility using the money she withdrew from her resident fund account. She stated she had to get her money from the office up front on Friday before the Medical Record Clerk (MRC) left for the weekend usually between 4:30 and 5:00 PM because if she did not get her money on Friday she would not be able to access any money until Monday when the MRC returned to work. Resident #15 stated that at times the MRC was off or left early on Friday and she was not aware so again she would go all weekend without being able to access her money.</p>	F 567			

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F 567	Continued From page 25 An interview was conducted with the MRC on 06/24/21 at 2:33 PM. The MRC stated that she was trained to access resident funds if the resident wished to withdrawal money out of their resident fund account. The MRC stated that she generally worked Monday through Friday and the residents would generally come to her before Friday if they wanted money for the weekend but stated generally no one from the business office worked on the weekends and no other staff member had access to money if a resident wanted to withdrawal money on the weekend. The MRC did state that for the last few Saturdays she had worked part of shift on Saturday so during those times the residents would have access to their money but other then that they would need to get it Friday before she left work because there was no one that had access to the resident funds in the facility over the weekends. An interview was conducted with the Administrator on 06/25/21 at 3:34 PM. The Administrator stated that the only time the residents would have access to their money on the weekend was if the MRC worked the weekends which did not happen often. He stated the issue came up when he first arrived at the facility approximately 8 weeks ago and he asked the resident council to vote on what was appropriate for the weekends as far as having access to their money. The Administrator stated he did not follow up with the resident council to see what they voted. The Administrator stated that he expected the residents to be able to access their money when they want or needed it even on the weekends.	F 567			
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir	F 578		7/26/21	

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F 578	Continued From page 26 CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.	F 578			

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F 578	<p>Continued From page 27</p> <p>Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record reviews and staff and resident interviews the facility failed to maintain accurate Advanced Directives in the residents' medical record for 2 of 27 residents reviewed for Advanced Directives (Resident #45 and #11).</p> <p>The findings included:</p> <p>1. Resident #45 was admitted to the facility on 05/11/21 with diagnoses that included lung cancer.</p> <p>The admission Minimum Data Set assessment dated 05/18/21 indicated Resident #45 was cognitively intact.</p> <p>A review of Resident #45's care plan dated 05/26/21 indicated the Resident was a Full Code and a review of the Full Code status would be reviewed in 90 days.</p> <p>A review of Resident #45's electronic medical record revealed there was no physician order for an Advanced Directive. Further review of the medical revealed a Do Not Resuscitate or DNR golden rod form dated 04/20/21 that was scanned into the electronic medical record.</p> <p>A review of the Nurse Practitioner's progress note dated 06/14/21 indicated Resident #45 was a DNR.</p> <p>During an interview with Resident #45 on 06/22/21 at 11:17 AM the Resident explained that</p>	F 578	<p>#1 Residents #45 and #11 advanced directives have been updated on 7/20/21 ordered as indicated, and care planned.</p> <p>#2 On 7/20/21 an audit of resident advanced directives were completed to ensure advanced directives are accurate, ordered as indicated, and care planned.</p> <p>#3 Advanced Directives have been added to Nursing Admissions Checklist to ensure admitting nurse confirms Advanced Directives. Advanced Directives will be reviewed in Morning Clinical Meeting review of New Admissions. Nursing staff educated on Admissions Checklist to include Advanced Directives. Social Worker to validate Advanced Directives for all new admissions are correct in Morning Clinical Meeting. Advanced Directives will be audited 5 days per week for four (4) weeks, then weekly for eight (8) weeks and as necessary thereafter. Newly hired staff will receive education by 7/26/21 and during orientation.</p> <p>#4 The Administrator will report findings of the monitoring to the Interdisciplinary Team (IDT) during QAPI meetings monthly for three (3) months and will make changes to the plan as necessary to maintain compliance with Advanced Directives</p>		

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F 578	<p>Continued From page 28</p> <p>her desire for her code status was to be a considered Do Not Resuscitate and stated she had given the facility a copy of her DNR form on her admission to the facility.</p> <p>During an interview with the facility Social Worker (SW) on 06/22/21 at 2:22 PM she explained that she started at the facility at the beginning of March 2021 and had not had a chance to complete anything since she arrived at the facility. The SW stated that she was not involved in the Advanced Directive process except for the care plan part. She continued to explain that she was able to complete one month of audits for the Advanced Directives but could only recall one discrepancy which she corrected immediately.</p> <p>An interview was conducted with the Director of Nursing (DON) on 06/24/21 at 3:38 PM. The DON explained that every resident admitted to the facility was considered a Full Code until they learned otherwise. She stated the Social Worker or the Physician would address with the resident what their desired Advanced Directive was and once it was established the order was written and the electronic medical record was updated. The DON added that the care plan was initiated by the Social Worker. The DON stated that her expectation was that the Advanced Directive process be followed which was that the Social Worker obtain the order for the desired Advanced Directive and initiate the care plan for that specific Advanced Directive.</p> <p>On 06/25/21 at 3:13 PM during an interview with the Administrator he explained that the Social Worker was responsible for obtaining and updating the Advanced Directives as well as initiating the care plan. He added if Resident</p>	F 578			

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F 578	<p>Continued From page 29</p> <p>#45's desire was to be a DNR then he expected her medical record to reflect that.</p> <p>2. Resident #11 was readmitted to the facility on 12/18/20 with diagnoses that included sequelae of cerebral infarct (effects of a stroke), anemia and anxiety.</p> <p>A physician order dated 02/25/19 read, Do Not Resuscitate (DNR).</p> <p>A care plan initiated on 02/25/19 and revised on 10/05/20 read: Advance Directives Full Code. The goal of the care plan read; Resident #11 will have advance directives followed through next review period. The interventions included: the interdisciplinary team will periodically review advance directive with Resident #11 and family to ensure her wishes are honored and provide education as needed.</p> <p>The quarterly Minimum Data Set (MDS) dated 03/24/21 indicated that Resident #11 was cognitively intact for daily decision making and required extensive assistance with activities of daily living.</p> <p>During an interview with Resident #11 on 06/21/21 at 10:19 AM Resident #11 stated she had been at the facility for a while and had chosen to be a DNR. She stated that she had told the facility staff what her wishes were but that had been a couple of years ago and could not recall who she had told.</p> <p>An interview was conducted with the facility Social Worker (SW) on 06/22/21 at 2:22 PM. The SW stated she started at the facility at the beginning of March 2021 had not had a chance to complete</p>	F 578			

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F 578	Continued From page 30 anything since she arrived at the facility. She added that she was not involved in the advance directive process except for the care plan piece. The SW again explained that she was able to complete one-month of audits but could only recall one discrepancy but could not recall what the discrepancy was but stated she corrected it immediately. The SW stated she had no idea the code status of Resident #11 nor could she speak to her care plan. The SW stated that during her time at the facility she had not initiated or edited Resident #11's advance directive care plan. An interview was conducted with the Director of Nursing (DON) on 06/24/21 at 3:58 PM. The DON stated everyone that admitted to the facility was a full code until they learned otherwise. She stated that the SW or the Physician would address with the resident code status and advance directives and once it was established the order was written and the electronic medical record updated, and a care plan initiated. The DON stated that the SW should be initiating and updating care plans on an ongoing basis and if Resident #11 had an order for a DNR then her care plan should reflect a DNR status as well. An interview was conducted with the Administrator on 06/25/21 at 3:13 PM. The Administrator stated that the SW was responsible obtaining and updating advance directives including care plans. He added that if Resident #11 had an order for a DNR then he expected the care plan to reflect that was well.	F 578			
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes.	F 580		7/26/21	

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F 580	<p>Continued From page 31</p> <p>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-</p> <p>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;</p> <p>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);</p> <p>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or</p> <p>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).</p> <p>(ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.</p> <p>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-</p> <p>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or</p> <p>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.</p> <p>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).</p> <p>§483.10(g)(15)</p>	F 580			

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F 580	<p>Continued From page 32</p> <p>Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observations, record review, and facility staff interviews, the facility failed to notify a resident's family of the development of a pressure ulcer (Resident #210) for 1 of 2 resident's reviewed for pressure ulcers.</p> <p>Findings Included:</p> <p>Resident #210 was admitted to the facility on 10/18/20 with diagnoses that included end stage renal disease, diabetes mellitus with complication, muscle weakness, and Alzheimer's disease.</p> <p>Review of Resident #210's care plan dated 10/30/20 revealed a care plan for "Resident #210 has potential for pressure ulcer development related to impaired mobility, incontinence, Alzheimer's, anemia, diabetes, and kidney failure. Deep tissue injury to left heel 12/1/20." Interventions included administer treatments as ordered and monitor for effectiveness; assess and document status of wound perimeter, wound bed, and healing progress.</p> <p>A physician's order was written on 12/02/20 for Resident #210's left heel to be cleaned with wound cleanser, pat dry, apply a moisturizer cream and wrap with roll gauze daily on day shift.</p>	F 580	<p>#1 Resident #210 no longer resides in the facility</p> <p>#2 Residents at risk for development of pressure ulcers have potential to be affected. Audit of residents with pressure ulcers was completed by 7/26/21 to ensure family had been notified of status of pressure ulcer.</p> <p>#3 Notification of change in condition, to include new or worsening pressure ulcers. 24 hour report will be reviewed in Morning Clinical Meeting to ensure notifications are documented for any changes in condition. Notifications of change in condition will be audited 5 days per week for four (4) weeks, then weekly for eight (8) weeks and as necessary thereafter. Newly hired staff will receive education by 7/26/21 and during orientation.</p> <p>#4 The Administrator will report findings of the monitoring to the Interdisciplinary Team (IDT) during QAPI meetings monthly for three (3) months and will make changes to the plan as necessary to maintain compliance with Notifications.</p>		

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F 580	<p>Continued From page 33</p> <p>Resident #210's wound physician notes revealed a note dated 12/08/20 for an initial exam of a left heel deep tissue injury. Per the note, the wound was 100% closed and measured 7 centimeters (cm) X 5 cm X 0 cm.</p> <p>A review of Resident #210's discharge Minimum Data Set dated 12/30/20 revealed Resident #210 to be cognitively impaired for daily decision making. Resident #210 was coded as having one or more unhealed pressure ulcers or injuries. The wound was coded as one unstageable pressure injury that presented as a deep tissue injury.</p> <p>Resident #210's electronic progress notes for December 2020 revealed no documentation of the facility notifying Resident #210's representative of the development of the pressure wounds to Resident #210's heels.</p> <p>Interviews with nurses scheduled to have worked with Resident #210 during her admission were unsuccessful.</p> <p>An interview with the Director of Nursing (DON) on 06/25/21 at 1:00PM revealed it was the responsibility of the hall nursing staff to notify a resident's representative of a change in the resident's condition. She stated the development of a pressure ulcer would warrant notification to the representative via telephone call. She stated after the telephone call was completed, a progress note should be placed in the resident's electronic medical record. The DON reported if there was not a progress note in the electronic medical record, then the notification must not have occurred. The DON reported it was her</p>	F 580			

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F 580	Continued From page 34 expectation that the family of Resident #210 should have been notified of the development of a pressure wound to Resident #210's left heel when it was first observed. An interview with the Administrator on 06/25/21 at 2:45PM, he reported it was his expectation that a resident's power of attorney or representative be made aware of the development of pressure ulcers and documentation be placed in the electronic medical record.	F 580			
F 584 SS=E	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; §483.10(i)(3) Clean bed and bath linens that are	F 584		7/26/21	

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F 584	<p>Continued From page 35 in good condition;</p> <p>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);</p> <p>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;</p> <p>§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</p> <p>§483.10(i)(7) For the maintenance of comfortable sound levels.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, record reviews, staff and Resident interviews the facility failed to clean and sanitize the doorframes, label and store residents' personal care items and failed to label and store residents' personal care items in 2 of 8 bathrooms (shared bathroom of rooms #107-109, #202-204, and #204-#206) and failed to ensure walls and doors were free from holes and scratches for 2 of 8 bathrooms (shared bathroom of rooms #107-109 and #202-204). The facility also failed to ensure 2 of 3 community shower rooms (500 hall and the 200 hall male shower rooms) were free of clutter, clean, sanitized and in good repair for areas reviewed for environment.</p> <p>The findings include:</p> <p>1. Resident #45 was admitted to the facility on 05/11/21 with diagnoses that included lung cancer.</p>	F 584	<p>#1 Doorframes of shared bathrooms for #107-109, #202-204, and #204-#206 were cleaned and sanitized on 7/23/21 and holes and scratches to walls repaired and continue to remain clean and free of holes and scratches. Unit 200 and 500 shower rooms remain clean, sanitized, free of clutter, and in good repair. Personal toiletries were removed.</p> <p>#2 On 7/6/21 EVS Director completed audit of all shared restrooms and shower rooms and cleaned and sanitized as indicated. On 7/19/21 Maintenance Director completed full house audit of all shared restrooms and shower rooms restrooms to ensure they are in good repair. All deep cleans and repairs completed by 7/26/21. Personal toiletries labeled and bagged for each resident room.</p> <p>#3 On 7/1/21 EVS staff educated by Senior EVS Director on proper cleaning of</p>		

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F 584	<p>Continued From page 36</p> <p>The admission Minimum Data (MDS) set assessment dated 05/28/21 revealed Resident #45 was cognitively intact and required supervision with personal hygiene.</p> <p>During an interview with Nurse Aide (NA) #1 on 06/23/21 at 12:21 PM the NA explained that Resident #45 liked to take a partial bath every morning in her bathroom and she would provide the Resident with a washcloth and towel and would remove them after the Resident was finished with them. The NA continued to explain that Resident #45 was independent with stand by assist with bathing.</p> <p>a. On 06/23/21 at 2:25 PM an interview was conducted with Resident #45 who explained that the sanitary conditions of her bathroom were not acceptable with her in that there had been fecal matter on the doorframe of the adjoining room for days and that when she called it to the attention of the (unidentified) housekeeper several days prior, the housekeeper cleaned some of the fecal matter off but left some on the doorframe. The Resident stated she was not accustomed to living in a "mess" like the shape her bathroom was in.</p> <p>An observation was made of the shared bathroom between rooms #107-109 on 06/23/21 at 2:25 PM. The observation revealed a brown substance approximately 3 inches long and 1 inch at the widest point on the right side of the doorframe on room #109 side of the bathroom. The brown matter had an odor of feces.</p> <p>A subsequent observation of the shared bathroom of #107-109 on 06/24/21 at 8:59 AM remained unchanged.</p>	F 584	<p>resident restrooms and shower rooms, and detail cleaning process. Education will be ongoing weekly and upon hire. Resident restrooms and showers rooms will be cleaned and sanitized daily and as needed and will remain free of clutter and in good repair. Any repairs will be reported to maintenance and repaired as indicated. Staff will report needed repairs or cleaning during regular room rounds. Maintenance Director educated by Administrator by 7/26/21 on repairs and ongoing maintenance rounds to ensure resident rooms, shower rooms, and other areas are in good repair. Direct care staff educated by Administrator on labeling of resident toiletries, place in bag for use, and personal toiletries not left in shower rooms by 7/26/21. Basins should be labeled, cleaned, stored in a bag and hung in shared restroom until next use. Restrooms and shower rooms should be sanitized between each resident use. Newly hired staff will receive education by 7/26/21 and during orientation.</p> <p>#4 Resident restrooms and shower rooms are to be inspected by EVS Manager and/or Senior EVS Manager five (5) times weekly for four (4) weeks, then weekly for eight (8) weeks and as necessary thereafter. Staff will report needed repairs or cleaning during regular room rounds. The Administrator will report findings of the monitoring to the IDT during QAPI meetings monthly for three (3) months and will make changes to the plan as necessary to maintain compliance</p>		

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F 584	<p>Continued From page 37</p> <p>An interview was conducted with Housekeeper #1 on 06/24/21 at 11:18 AM. The Housekeeper reported he began employment on 06/03/21 but had worked in housekeeping for several years and was responsible for 100 hall. He explained that every resident room and bathroom was cleaned every day that involved dusting, disinfecting, sweeping, mopping and changing the trash in every resident room and their bathrooms.</p> <p>An interview was conducted with Nurse Aide (NA) #5 on 06/24/21 at 1:45 PM. The NA explained that Resident #45 liked to take a sponge bath ever morning in her bathroom and had asked the NA several times if she would clean her bathroom because it was dirty. The NA stated she did not notice the brown substance on the doorframe or she would have cleaned it herself.</p> <p>A subsequent observation of the shared bathroom of rooms #107-109 on 06/24/21 at 4:07 PM revealed the bathroom remained as noted above.</p> <p>A subsequent observation of the shared bathroom of rooms #107-109 on 06/25/21 at 8:34 AM revealed the bathroom remained as noted above.</p> <p>An interview and observation were made of the shared bathroom between rooms #107-109 with Housekeeper #1 on 06/25/21 at 8:49 AM. The Housekeeper confirmed he cleaned room #107 and the adjoining bathroom. He stated he did not notice the brown stain on the doorframe or he would have cleaned it off then proceeded to wash the brown substance off the doorframe.</p>	F 584			

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F 584	<p>Continued From page 38</p> <p>An interview was conducted with the Housekeeping Supervisor (HKS) on 06/25/21 at 9:17 AM. The HKS explained the housekeepers were responsible for cleaning the residents' bathrooms every day which included sweeping, mopping and disinfecting the commonly touched areas. The HKS stated the housekeepers should be more vigilant to the commonly touched areas because it was unacceptable for the brown substance to have been on the doorframe for days.</p> <p>During an interview with the Director of Nursing (DON) on 06/25/21 at 10:30 AM she explained that keeping the bathrooms in a clean sanitary condition should be a joint effort by both nursing and housekeeping and both departments should be accustomed to making sure they done that.</p> <p>b. On 06/23/21 at 2:25 PM an interview was conducted with Resident #45 who explained that the sanitary conditions of her bathroom were not acceptable with her in that there was a wash basin in the floor next to the commode (left side) with several dirty wet washcloths (brown substance on washcloths) that had been there for days. Resident #45 continued to explain that on the left side of the small sink was a clear plastic cup and open bottles of mouthwash and body wash and on the right side was a clear plastic cup that contained a toothbrush and toothpaste and an open bottle of body wash setting next to the cup. The Resident stated there was a towel and used washcloth hanging on the towel bar mounted on the right wall beside the sink all of which the Resident stated were not her personal toiletries. The Resident stated she was not accustomed to living in a "mess" like the shape her bathroom was in.</p>	F 584			

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F 584	<p>Continued From page 39</p> <p>On 06/23/21 at 2:25 PM an observation was made of Resident #45's bathroom #107. There was an unlabeled wash basin that contained several dirty (brown substance) wet washcloths stored on the floor on the right side of the commode. Setting on the left side of the small sink was a clear plastic cup and open bottles of mouthwash and body wash. On the right side of the sink was a clear plastic cup that contained a toothbrush and toothpaste and setting next to the cup was an open bottle of body wash. All of which were unlabeled and not belonging to Resident #45. On the mounted towel rack on the right side of the wall was a towel and used washcloth that also did not belong to the Resident. The Resident stated she was not accustomed to living in a "mess" like the shape her bathroom was in.</p> <p>A subsequent observation of the shared bathroom of #107-109 on 06/24/21 at 8:59 AM remained unchanged.</p> <p>An interview was conducted with Nurse Aide (NA) #5 on 06/24/21 at 1:45 PM who confirmed she cared for Resident #45. An observation was made of Resident #45's bathroom #107 during the time of the interview. The observations remained the same as described in the previous observation. The NA explained that the residents' personal toiletries should be in a bag and labeled with their names and stored in their drawers. She continued to explain that she did not know who the unlabeled wash basin belonged to but that it should not be stored on the floor.</p> <p>A subsequent observation of the shared bathroom of rooms #107-109 on 06/24/21 at 4:07 PM revealed the bathroom remained as noted</p>	F 584			

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F 584	<p>Continued From page 40 above.</p> <p>A subsequent observation of the shared bathroom of rooms #107-109 on 06/25/21 at 8:34 AM revealed the bathroom remained as noted above.</p> <p>During an interview with the Director of Nursing (DON) on 06/25/21 at 10:30 AM she explained that the residents' personal toiletries should be labeled with their names and stored in a bag or at their bedside. She continued to explain that the nurse aides should clean the bathrooms after they have assisted the residents and that they should take their toiletries back to the residents' bedside. The DON stated that keeping the bathrooms in a clean sanitary condition should be a joint effort by both nursing and housekeeping.</p> <p>c. On 06/23/21 at 2:25 PM an interview was conducted with Resident #45 who explained that the sanitary conditions of her bathroom were not acceptable with her in that there had been a grab bar lying underneath the sink since she was transferred into the room (06/09/21) and holes in the wall on the right side of the commode where the grab bar was apparently once mounted. Resident #45 stated there were multiple scratch marks on both inside bathroom doors and black marks on the walls and doorframes. The Resident stated she was not accustomed to living in a "mess" like the shape her bathroom was in.</p> <p>An observation was made on 06/23/21 at 2:25 PM of Resident #45's shared bathroom between rooms #107 and 109 revealed a grab bar lying on the floor underneath the sink and holes in the wall on the right side of the commode. There were also multiple scratch marks on the inside doors</p>	F 584			

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F 584	<p>Continued From page 41 as well as multiple black scratch marks on the walls and doorframes.</p> <p>A subsequent observation of the shared bathroom of rooms #107-109 on 06/24/21 at 8:59 AM remained unchanged.</p> <p>A subsequent observation of the shared bathroom of rooms #107-109 on 06/24/21 at 4:07 PM revealed the bathroom remained as noted above.</p> <p>An observation of the shared bathroom of rooms #107-109 on 06/25/21 at 8:34 AM revealed the bathroom remained as noted above.</p> <p>During an interview and observation of the shared bathroom between rooms #107-109 with the Maintenance Supervisor (MS) on 06/25/21 at 9:06 AM the MS stated he made walking rounds of resident rooms, bathrooms and common areas about once a month but had not made one this month. He explained the facility had no major projects in progress at the current time. The MS stated that when the staff noticed a repair that needed to be made they were supposed to put the request into the computer TELs system and he would get it or they would verbally inform him of what needed to be done. The MS stated he was not made aware of the grab bar underneath the sink on the floor but that it was not there about 2 weeks ago. The MS also remarked that the holes in the wall and the black scratch marks on the walls, doors and doorframes needed to be repaired.</p> <p>An interview was conducted with the Administrator on 06/25/21 at 11:28 AM. The Administrator explained that the residents'</p>	F 584			

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F 584	<p>Continued From page 42</p> <p>personal toiletry items should be labeled and stored in their rooms because of the limited space in the bathrooms. He indicated that all departments should be vigilant in identifying issues that need to be repaired and fill out the work orders to correct those issues.</p> <p>2. On 06/24/21 at 3:18 PM during an observation of the 500 hall shower room was made. The room was noted to be cluttered and in disarray. Stored in the spa tub was an empty jar of zinc oxide cream and 3 wet wash cloths. The first privacy curtain had 5 hooks disconnected from the curtain, limiting complete privacy. On the floor in front of the spa tub was an unlabeled wash basin, gloves, toothbrush and discarded toilet paper. On the floor behind the commode was a silver pipe and above the commode the vent on the ceiling had one side of the door hanging open. In the shower area was an opened bottle of unlabeled body wash, a toothbrush, washcloth, toilet paper and plastic shower cap on the floor as well as two brown substances that appeared to be fecal material. Stored in the cabinet were multiple used and unlabeled toiletry items of deodorants, lotions, toothbrushes, toothpastes, body washes, razors, shaving creams, combs and hairbrushes. Toiletry items were both facility and residents' personal property.</p> <p>An interview was conducted with Nurse Aide (NA) #7 on 06/24/21 at 3:48 PM who confirmed she was scheduled for 500 hall at that time. The NA explained that the 500 hall shower room was used by the residents' on 500 hall as well as other residents in the facility and she did not know what nurse aide used the shower room last. Regardless, the NA explained that the shower room should be kept neat and orderly for the</p>	F 584			

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F 584	<p>Continued From page 43</p> <p>residents and everyone should pick up after themselves after giving the residents their showers. The NA continued to explain that the toiletry items should have the residents' names on them and they should not be stored in the cabinet but that they could keep extra unopened items stored in the cabinet to keep the staff from having to walk down the hall to get them. The NA added the staff should pt the resident's name on the item when the item was used for the resident. The NA also stated the spa should not be a storage place for the lifts, sheets etc. that were in the spa tub. NA #7 reported that the housekeeper on the hall was supposed to have cleaned the shower room at the end of their shift.</p> <p>During an interview and observation of the 500 hall shower room with the Maintenance Supervisor (MS) on 06/25/21 at 9:06 AM he explained the staff were supposed to report the needed repairs that he did not identify on his walking rounds which were about once a month but that he had not made them this month. The MS stated he was not aware of the vent door hanging down above the commode nor the pipe on the floor behind the commode.</p> <p>On 06/25/21 at 9:17 AM an interview and observation were made of the 500 hall shower room with the Housekeeping Supervisor (HKS) who explained the housekeepers were supposed to sweep, mop and disinfect the showers at the end of the shift. The HKS noted the brown substance on the shower staff floor and stated it should have been cleaned up the day before.</p> <p>3. An observation and interview conducted with Nurse Aide (NA) #7 of the 200 hall male shower room on 06/24/21 at 4:23 PM was conducted.</p>	F 584			

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F 584	<p>Continued From page 44</p> <p>The shower room had multiple areas on all four walls of crackling and peeling of paint, and the fluorescent light above the spa tub had one side of the light cover hanging loose. The NA explained that the shower room was renovated about 2 year ago and the paint started peeling shortly after that. The NA was not aware of the condition of the light cover above the spa tub but stated someone should have noticed it and put in a work order to maintenance.</p> <p>An interview and observation of the 200 hall male shower room was conducted with Nurse Aide (NA) #4 on 06/24/21 at 6:30 PM. The NA explained she will occasionally bring a resident into the shower room but she didn't like to because of the condition of the room. The NA stated she was not aware of the light cover hanging down over the spa tub because she does not go on that side of the room where the spa tub was stationed because she does not use it.</p> <p>On 06/25/21 at 9:06 AM an interview and observation were made of the 200 hall male shower room with the Maintenance Supervisor (MS). The MS noted the condition of the paint peeling off the walls and the light cover hanging down over the spa tub. The MS stated he had not made a round in the shower room for a while and did not know the peeling paint was that bad and that the light cover needed to be fixed.</p> <p>An interview was conducted with the Administrator on 06/25/21 at 11:28 AM who explained he had not been in the 200 hall or 500 hall shower rooms for a while but was aware of the peeling paint on the wall in the 200 hall shower room but not the light fixture hanging down above the spa tub. The Administrator</p>	F 584			

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F 584	<p>Continued From page 45</p> <p>continued to explain that he was not aware of the vent door hanging down above the commode in the 500 hall shower room. The Administrator indicated that all staff should be active in filling out repair requisitions when the issues were discovered so they could be repaired.</p> <p>4. Observation on 06/24/21 at 11:10 AM revealed a bathroom joining rooms 204 and 206 which included:</p> <ul style="list-style-type: none"> a. A strong stale urine odor b. A dark brown substance smeared on the exterior toilet base and on the wall, which appeared to be feces was located to the left side of the commode under the handrail c. A urinal which contained a dark yellowish-brown crusty substance around the rim and on the sides was located on the floor behind the commode d. Two additional urinals were hanging from the handrail which contained a similar crusty substance. e. Two used washed basins were sitting in the floor of the bathroom- one of the basins contained a soiled wash rag that was dried and stiff in texture and the other was empty. f. A soiled bed pan which hung from a hook above the toilet. The urinals, bed pans, and wash basins were observed with no identifiable labeling included. g. One approximately 5-foot unidentifiable piece of thin white plastic which appeared to be a form of molding leaned up against the wall behind the commode <p>During the observation, Nurse Aide (NA) #11 entered the bathroom to empty a urinal for Resident #17. NA #11 was interviewed about the items in the bathroom being heavily soiled and</p>	F 584			

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F 584	<p>Continued From page 46</p> <p>none of the items being labeled, she responded saying she was not sure who the items belonged to or why they were heavily soiled with a reddish-brown crusty substance on the interior and exterior surfaces. NA #11 emptied the urinal into the commode and returned it to Resident #17 before returning to the bathroom to discard all unlabeled items, doff her gloves, and wash her hands. NA #11 stated she had been taught that items should include the residents' name for easily identifying the items and to avoid cross-contamination between residents. She indicated housekeeping staff cleaned the bathrooms daily and she was not sure why there was a dark brown substance on the toilet or the wall which she identified to likely be feces and stated she would ask the housekeeper to clean it.</p> <p>An interview on 06/24/21 at 11:15 AM with Resident #17 revealed he used a urinal most of the time and the toilet for bowel elimination. He stated housekeeping comes in to clean the bathroom daily and stated he had only had one urinal provided to him. He indicated it would be nice to get a new one occasionally, but he managed with the one he currently had and although heavily soiled did not like causing any problems, so he had not asked for another one.</p> <p>An interview on 06/25/21 at 8:30 AM with the Director of Nursing revealed she expected all hygiene items such as bed pans, urinals, and wash basins to be labeled and stored properly in separate bags and discarded when heavily soiled.</p> <p>An interview on 06/25/21 at 9:23 AM with the Housekeeping Director revealed he expected bathrooms to be cleaned daily to include sweeping, mopping, and disinfecting surfaces. He</p>	F 584			

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F 584	Continued From page 47 stated the bathroom should be free of feces, urine odor, and items should be discarded from the room when a resident was discharged. He was unsure why there would be feces on the toilet and the wall in a resident's bathroom but felt it to be unacceptable. The Housekeeping Director stated it was the NA's responsibility to provide urinals, bed pans, and wash basins to residents and label them for ease of identification, but it was a joint effort between housekeeping and nursing department to discard the items when soiled. An interview on 06/25/21 at 2:46 PM with the Administrator revealed he expected bathrooms to be cleaned and sanitized daily to include sweeping, mopping, and disinfecting surfaces. He indicated if the toilet or walls became soiled, housekeeping should clean and disinfect the areas. He indicated nursing staff was to label items and store them in bags properly after each use.	F 584			
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the	F 585		7/26/21	

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F 585	<p>Continued From page 48</p> <p>facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.</p> <p>§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.</p> <p>§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:</p> <p>(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;</p> <p>(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for</p>	F 585			

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F 585	Continued From page 49 example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.	F 585			

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F 585	<p>Continued From page 50</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interview the facility failed to provide a written grievance summary with resolution to the resident who filed a grievance for 2 of 2 residents (Resident #15 and Resident #24).</p> <p>The findings included:</p> <p>Review of a facility policy titled, "Resident and Family Grievances" revised on 10/28/20 and implemented on 11/01/20 read in part, the resident will be provided a written summary of the resolution (except any information protected by HIPPA or labor laws). Every attempt will be made to provide this summary within 48 hours of receiving the grievance. An acknowledgment signed by the resident validating he or she has received a written response will be maintained with the grievance.</p> <p>1. Resident #15 was readmitted to the facility on 10/17/20 with diagnoses that included diabetes, heart failure, osteoarthritis, and others.</p> <p>A grievance form dated 03/16/21 reported by Resident #15 read in part, dietary did not ask what my dinner preferences were. The findings indicated that the Dietary Aide received disciplinary action and education. The resolution stated nothing regarding the dietary issue. The form indicated the findings were shared verbally with Resident #15. No written follow up was noted.</p> <p>The comprehensive Minimum Data Set (MDS) dated 04/09/21 revealed that Resident #15 was cognitively intact for daily decision and had no</p>	F 585	<p>#1 Administrator met with Resident #15 and #24 regarding grievances by 7/26/21 rectify and make changes as indicated to solve the grievance.</p> <p>#2 Department heads interviewed residents to update dietary preferences by 7/26/21. Preferences were then uploaded into PCC. Resident interviews conducted on 6/29/21 to ensure grievances are addressed. Department Heads round five (5) per week to ensure resident grievances are addressed and resolved. Grievance process was explained and voted on by Resident Council on 7/1/21 to ensure residents are aware of and in agreement with the Grievance process.</p> <p>#3 Administrator provided education to department heads and staff on grievance process resident rights as it relates to dietary preferences by 7/26/21. Resident grievances are reported in daily stand up meeting, grievance is addressed by Department Head assigned, returned to the Administrator or Designee, and logged on grievance log when resolved. A letter confirming resolution of grievance is given to resident or sponsor upon resolution. Senior Dietary Director educated Dietary Manager and Dietary staff on grievance process and resident rights as it relates to dietary preferences by 7/26/21. Newly hired staff will receive education by 7/26/21 and during orientation.</p> <p>#4 Residents with grievances reported will be interviewed by Administrator weekly for eight (8) weeks to ensure satisfaction with resolution or if further</p>		

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F 585	<p>Continued From page 51</p> <p>signs or symptoms of delirium noted during the assessment reference period. The MDS further indicated that Resident #15 required extensive assistance with activities of daily living.</p> <p>A grievance form dated 06/11/21 reported by Resident #15 read in part, I requested my food be served in styrofoam containers and on this day, they sent me regular plate and silverware. The findings of the investigation read, food was already plated, will have Resident #15 put her request in sooner. The resolution stated, will continue to monitor. The form indicated the results were shared verbally with Resident #15. No written follow up was noted.</p> <p>A grievance form dated 06/12/21 reported by Resident #15 read in part, someone else made the decision as to what I would eat for dinner and sent beef and I don't eat beef. The findings of the investigation stated that Resident #15 did receive beef. The plan read, staff to inform dietary of patient dislike for beef. The resolution section contained no additional remarks and no written follow up was noted.</p> <p>An interview was conducted with Resident #15 on 06/21/21 at 12:50 PM. Resident #15 confirmed that she had filed multiple grievances on multiple occasions including 03/16/21, 06/11/21, and 06/12/21 regarding not being able to make choices about her meal preferences. Resident #15 stated that she still has issues with not being able to make a choice about what she gets for her meals. She stated that she had never received a written letter or follow up from the grievances she has filed, and the staff only reported that they would investigate the issue. Resident #15 again confirmed that once she filed</p>	F 585	<p>action is needed. The Administrator will report findings of the monitoring to the IDT during QAPI meetings monthly for three (3) months and will make changes to the plan as necessary to maintain compliance.</p>		

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F 585	<p>Continued From page 52</p> <p>the grievance, she had heard nothing from them, nor had she received any letter informing her of the steps that were taken to resolve her issues.</p> <p>The Administrator was interviewed on 06/25/21 at 3:34 PM. The Administrator confirmed that he was the grievance official and had received multiple grievances from Resident #15 regarding dietary issues. The Administrator stated that he would contact the Dietary Manager immediately and correct the issue and he did his best to resolve Resident #15's concerns. He added that whoever investigated the grievance should be following up with the resident but that he provided no written response or follow up to the resident.</p> <p>2. Resident #24 was admitted to the facility on 05/02/19 and most recently readmitted to the facility on 06/06/21 with diagnoses that included end stage renal disease, chronic obstructive pulmonary disease, heart failure, and others.</p> <p>The quarterly Minimum Data Set (MDS) dated 06/13/21 indicated that Resident #24 was cognitively intact for daily decision making with no signs or symptoms of delirium. The MDS further indicated that Resident #24 required extensive to total assistance with activities of daily living.</p> <p>Review of grievances filed by Resident #24 revealed 9 grievance forms were submitted on 06/14/21, all regarding concerns with dietary services. All 9 forms were assigned to the Dietary Manager for investigation. The forms provided some attempt at resolution like updating Resident #24's like and dislikes and educating the dietary staff. The 9 forms indicated that no written resolution or follow up was provided. The forms were signed by the Administrator.</p>	F 585			

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F 585	Continued From page 53 An interview was conducted with Resident #24 on 06/21/22 at 2:45 PM. Resident #24 confirmed that she had filed multiple grievances on 06/14/21 all concerning the dietary department. Resident #24 stated that each time she reported issues to the Administrator he would state that he would investigate the issues and then she would not hear anything else about the concerns. Resident #24 confirmed that she had not received any written follow up regarding the grievances she filed on 06/14/21 and continued to have concerns with the dietary department. An attempt to speak to the Dietary Manager was made on 06/25/21 at 2:30 PM and was unsuccessful. The Administrator was interviewed on 06/25/21 at 3:34 PM. The Administrator confirmed that he was the grievance official and had received multiple grievances from Resident #24 on 06/14/21 regarding dietary issues. The Administrator stated that he would contact the Dietary Manager immediately and correct the issue and he did his best to resolve Resident #24's concerns. In addition, he would provide the Dietary Manager the grievances for follow up and investigation. He added that whoever investigated the grievance should be following up with the resident but that he provided no written response or follow up to the resident.	F 585			
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be-	F 657		7/26/21	

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F 657	<p>Continued From page 54</p> <p>(i) Developed within 7 days after completion of the comprehensive assessment.</p> <p>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--</p> <p>(A) The attending physician.</p> <p>(B) A registered nurse with responsibility for the resident.</p> <p>(C) A nurse aide with responsibility for the resident.</p> <p>(D) A member of food and nutrition services staff.</p> <p>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.</p> <p>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</p> <p>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, record reviews, staff and Resident interviews the facility failed to revise Resident #31's care plan to reflect being able to smoke independently for 1 of 1 resident reviewed for smoking.</p> <p>The findings</p> <p>Resident #31 was admitted to the facility on 11/13/19 with diagnoses that included cerebral vascular accident (CVA) and dementia.</p> <p>The annual Minimum Data Set (MDS)</p>	F 657	<p>#1 On Resident #31 smoking assessment completed on 7/20/21 and care plan updated to reflect him as a supervised smoker based on smoking assessment.</p> <p>#2 Audit of residents who smoke was completed by 7/26/21 by Unit Manager to ensure current smoking assessment was completed and care planned as indicated.</p> <p>#3 Smoking assessments will be completed upon admission and care planned accordingly. Audit of all smokers will be completed weekly for four (4)</p>		

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F 657	<p>Continued From page 55</p> <p>assessment dated 10/26/20 indicated Resident #31 was a tobacco user.</p> <p>The Safe Smoking Assessment dated 03/25/21 revealed the staff reviewed the policy for storage of smoking materials with Resident #31 and was deemed to be able to smoke independently.</p> <p>The quarterly MDS assessment dated 04/28/21 revealed Resident #31 had severe cognitive impairment.</p> <p>A review of the smoking care plan for Resident #31 revealed the care plan had not been updated since 08/20/20 when the Resident was deemed to be an unsafe smoker.</p> <p>On 06/21/21 at 3:52 AM during an interview and observation of Resident #31 he explained that he was an unsupervised smoker and was able to smoke anytime he desired outside. The Resident stated that he was able to light, smoke and extinguish the cigarette without assistance of staff.</p> <p>An interview was conducted with the MDS Coordinator (MDSC) on 06/25/21 at 9:34 AM. The MDSC explained that it was the nursing staff's responsibility to complete the smoking assessment on the residents and the Social Worker's responsibility to initiate the care plan and to update the care plan as needed. The MDSC acknowledged Resident #31's care plan had not been updated since 08/2020 and stated the care plan should have been updated to reflect his current smoking status.</p> <p>An interview with the Social Worker was unable to be attained.</p>	F 657	<p>weeks and then monthly for three (3) months by MDS Coordinator to ensure accuracy of smoking assessment and that care plan is updated. Nursing staff will be educated on smoking assessments by 7/26/21 and upon hire.</p> <p>#4 The Administrator will report findings of the monitoring to the IDT during QAPI meetings monthly for three (3) months and will make changes to the plan as necessary to maintain compliance.</p>		

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F 657	Continued From page 56 During an interview with the Director of Nursing (DON) on 06/25/21 at 10:28 AM she explained it was the Social Worker's responsibility to formulate or update the smoking care plans and that Resident #31's care plan should reflect his current smoking status which was that he could smoke unsupervised and anytime he desired outside. An interview was conducted with the Administrator on 06/25/21 at 11:28 AM. The Administrator stated that his expectation was that Resident #31 had an updated care plan that reflected his current unsupervised smoking status complete with the guidelines involved in the unsupervised smoking status.	F 657			
F 677 SS=E	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, record review, resident and staff interview the facility failed to perform routine incontinent care (Resident #7) and failed to provide scheduled showers (Resident #24, Resident #37, Resident #17, and Resident #45) for 5 of 10 residents reviewed for activities of daily living. Findings included: 1. Resident #7 was admitted to the facility on 03/09/21 with diagnoses that included diabetes.	F 677	#1 Residents #37, #17, #24, #7, and #45 to continue to receive ADL assistance as indicated per facility policy and as requested by resident #2 On 6/29/21 the Department Heads completed an audit of interviewable residents via resident questionnaire to ensure residents are getting ADL care per preference. If identified, concerns are addressed per the facility grievance process. #3 Nurse and CNA assignments will be	7/26/21	

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F 677	<p>Continued From page 57</p> <p>A self-care deficit care plan dated 03/22/21 revealed Resident #7 was dependent for bed mobility, dressing, toileting, hygiene, and bathing and required 1-2 staff assistance.</p> <p>A bowel and bladder care plan dated 3/22/21 indicated Resident #7 was incontinent of bowel and bladder with interventions to clean peri-area with each incontinent episode.</p> <p>A recent quarterly Minimum Data Set dated 06/16/21 revealed Resident #7 was rarely or never understood and extensive to total dependent for all ADL care. The MDS further indicated Resident #7 was always incontinent of bowel and bladder and a Stage II pressure ulcer that was not present on admission.</p> <p>An observation of wound care provided by Nurse #8 on 06/24/21 at 3:20 PM revealed Resident #7 in bed. Nurse #8 entered the room to perform wound care therapy to her Stage II pressure ulcer to her sacrum. Nurse #8 pulled back the sheet that was partially draped over Resident #7 and realized Resident #7 needed incontinence care because her blue brief was soiled. There was no stool present in the brief; however, it was heavily saturated with urine. As the heavily soiled brief was removed by Nurse #8, it was observed to contain a dark yellow color inside, a strong odor, and the inside of the brief showed the inside lining to have visible cotton shedding of the liner inside. As the brief was removed, the skin below revealed a soiled dressing labeled 6/24 at 9:23 AM covering a Stage II pressure ulcer. After the incontinence care was provided, she applied a clean brief which she wrapped around Resident #7 twice due to the brief being oversized, then</p>	F 677	<p>reviewed and adjusted as necessary to better meet the needs of each resident. Shower Schedule grid was updated with resident preferences. DON and/or Unit Manager to verify ADL care performed appropriately and assignment sheet followed. Manager on Duty will ensure showers, ADL care, out of bed preferences are occurring on weekends via rounding, and resident interviews. CNA and Nursing schedules were changed on 6/27/21 to better meet the needs of the residents. Department Heads round five (5) per week to ensure resident grievances are addressed and resolved, showers received per their preference, call bells answered timely, and incontinence care given as needed. Manager on Duty will round Saturdays and Sundays ensure resident grievances are addressed and resolved, showers received per their preference, call bells answered timely, and incontinence care given as needed. Newly hired staff will receive education by 7/26/21 and during orientation.</p> <p>#4 The Administrator will report findings of the monitoring to the Interdisciplinary Team (IDT) during QAPI meetings monthly for three (3) months and will make changes to the plan as necessary to maintain compliance.</p>		

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F 677	<p>Continued From page 58 covered Resident #7 with her sheet.</p> <p>An interview on 06/24/21 at 3:38 PM with Nurse #8 revealed she was assigned to provide treatments to Resident #7 and had first completed them around 9:00AM. Nurse #8 stated when she applied the treatment to Resident #7's sacrum that morning, she did not require incontinence care and therefore applied the dressing and requested NA #7 get Resident #7 up to her chair. Nurse #8 stated she had not returned to Resident #7's room until 3:20 PM when she was told the sacral dressing had become soiled and needed a PRN dressing change applied and found Resident #7 to be heavily saturated with urine. Nurse #8 stated the NA assigned to the resident typically performed routine incontinence care for the residents; however, she would provide it if needed when she did wound care; however, she had not provided incontinence care prior to performing the pressure ulcer treatment during the observation.</p> <p>An interview on 06/24/21 at 3:46 PM with NA #3 revealed she was not assigned to Resident #7 and had not provided incontinence care to her during the day shift on 06/24/21.</p> <p>An interview on 06/24/21 at 3:49 PM with NA #7 revealed she was assigned to care for Resident #7 on 06/24/21 during day shift. She indicated she had not performed incontinence care on Resident #7 during her shift. NA #7 indicated 3rd shift had reported she had incontinent care shortly before 7 AM on 06/24/21 and NA #7 had gotten Resident #7 up to her chair. Shortly after breakfast, Nurse #8 approached NA #7 and said she needed to perform Resident #7's ulcer bandages and needed her put back to bed. NA #7</p>	F 677			

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F 677	<p>Continued From page 59</p> <p>reported she put Resident #7 back to bed and thought Nurse #8 would perform incontinence care while performing the treatment, so she did not include her on the routine incontinence round checks after that time. She stated she gotten busy after putting Resident #7 to bed and did not realize how long had passed since Resident #7 had been changed. NA #7 said she had been taught to check residents for toileting and incontinence needs every 2 hours.</p> <p>An interview on 06/24/21 at 3:51 PM with NA #11 revealed she was not assigned to work with Resident #7 and had not provided incontinence care to her during day shift on 06/24/21.</p> <p>An interview on 06/24/21 at 4:36 PM with the Director of Nursing revealed she expected each resident to be checked for the need of toileting or incontinence care every 2 hours. She stated NA #7 and Nurse #8 should have communicated clearly about who would provide incontinence care to Resident #7's during wound care and throughout the remainder of the shift. The DON explained it was unacceptable for a resident to not be checked from 9:23 AM to 3:20 PM and be required to sit in a heavily urine saturated brief.</p> <p>An interview on 06/25/21 at 2:46 PM with the facility Administrator revealed he expected staff to perform rounds frequent enough to ensure all residents were clean and dry.</p> <p>2. Resident #24 was admitted to the facility on 05/02/19 and most recently readmitted on 06/06/21 with diagnoses that included end stage renal disease, chronic obstructive pulmonary disease, heart failure, weakness, and others.</p>	F 677			

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F 677	<p>Continued From page 60</p> <p>The facility's shower schedule revealed that Resident #24 was scheduled for a shower every Wednesday evening.</p> <p>Review of Resident #24's bathing record dated May 2021 indicated that on Wednesday 05/05/21 Resident #24 received a partial bed bath from Nurse Aide (NA) #6, on Wednesday 05/12/21 Resident #24 received a partial bed bath from NA #6, on Wednesday 05/19/21 Resident #24 received a partial bed bath from NA #6 and on Wednesday 05/26/21 no shower or bed bath was provided by NA #2.</p> <p>The quarterly Minimum Data Set (MDS) dated 06/13/21 revealed that Resident #24 was cognitively intact and required total assistance from staff with bathing. The MDS further indicated no rejection of care during the assessment reference period.</p> <p>Review of Resident #24's bathing record dated June 2021 indicated that Wednesday 06/02/21 no bathing activity was provided in the evening by Nurse Aide (NA) #7, on Wednesday 06/09/21 no bathing activity was recorded in the evening at all, on Wednesday 06/16/21 a partial bed bath was provided in the evening by NA #6, and on Wednesday 06/23/21 no bathing activity was recorded at all.</p> <p>An interview was conducted with Resident #24 on 06/21/21 at 3:15 PM. Resident #24 was resting in her bed and was alert and oriented. She stated that she had agreed to have one shower a week on Wednesday evening because she preferred to bathe before bed. Resident #24 stated that one shower a week was fine with her because she</p>	F 677			

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F 677	<p>Continued From page 61</p> <p>really was not that active and she felt clean and refreshed with one shower a week but she did not generally get her showers on Wednesday's that were scheduled. She indicated that the last shower she had was approximately 2-3 weeks ago and the staff would generally tell her it was because they did not have enough staff nor enough time to take her to the shower. Resident #24 stated that if the staff were unable to give her a shower on Wednesday, she generally would take a partial bed bath just to get clean and put on a clean gown before she went to bed that night. Resident #24 again stated she wanted her one shower a week that she agreed upon with the facility.</p> <p>An interview was conducted with NA #6 on 06/23/21 at 10:38 AM. NA #6 confirmed that he cared for Resident #24 often and was familiar with her care. NA #6 confirmed that the facility had a shower book that contained the shower schedule and each day he worked he would look at the shower schedule to see who was scheduled to get a shower that day. NA #6 stated that if a resident refused a shower, he would report it to the nurse and document that in the electronic record under their bathing record. NA #6 confirmed that Resident #24 was scheduled for a shower on Wednesday evening, he stated that the first time he took her to the shower was sometime in April. He stated that Resident #24 liked to take her shower later on the shift and he would always offer to take her but she would want to wait until later in the shift and he just would not have the time to come back and give her a shower because he would be making a final round before the end of his shift. NA #6 stated that at times he would assist her with a bed bath if he did not have the time closer to the end of the</p>	F 677			

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F 677	<p>Continued From page 62</p> <p>shift to take her to the shower but he would always document that in the bathing record.</p> <p>An interview was conducted with NA #2 on 06/23/21 at 11:04 AM. NA #2 stated that she worked with Resident #24 from time to time but was familiar with her care. She could not recall what Resident #24's shower schedule was but stated she would check the shower schedule when she came in and see who was scheduled for one during that shift. NA #2 stated that if Resident #24 was scheduled for a shower and did not get one it was because there was not enough staff to do so. NA #2 state that generally they worked with 3 NAs on second shift and all they had time to do was dry the resident, turn the resident, and feed them their evening meal.</p> <p>An interview was conducted with the Unit Manager (UM) on 06/24/21 at 10:24 AM. The UM stated that she had recently spoken to the residents and obtained their bathing preferences and once she obtained them, she entered them directly into the electronic medical record where the task would populate to the NAs for completion. The UM stated that she did not check the shower book at the nurse's station, but she assumed the shower book aligned with the task in the electronic medical record. The UM stated that she expected the staff to complete the showers per the schedule as per the resident request.</p> <p>An interview was conducted with NA #7 on 06/24/21 at 12:29 PM. NA #7 confirmed that she cared for Resident #24 at times and was familiar with her care. NA #7 stated that when she arrived for her shift, she would check the shower book at the nurse's station and see who was scheduled for showers that day. NA #2 stated that on the</p>	F 677			

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F 677	<p>Continued From page 63</p> <p>evening shift there were only 3 NAs and that did not leave enough staff to complete the showers. She explained if there were 4 or more staff that did allow for some showers to be given but not all of them. She stated that she had told the Director of Nursing (DON) on numerous occasions that there was not enough staff to get all the showers done. NA #2 stated that when there were 3 NAs working on the evening shift all they had time to do was feed the residents the evening meal, dry them once or twice and turn them.</p> <p>An interview was conducted with the DON of 06/24/21 at 3:58 PM. The DON stated that the UM had went around and spoke to the residents about their bathing preferences but was not sure what she had done with the information she collected because the facility was in the process of switching to 12 hour shifts. The DON stated that whatever the resident decided about their showers was what she expected to happen. The DON explained that 90-95% of the staff they had was agency and that sometimes staffing was "hit or miss" because at times the agency staff would confirm their assignment but then just not show up. The DON stated that they scheduled enough staff, but we don't always end up with enough staff.</p> <p>3. Resident #37 was readmitted to the facility on 08/13/19 with diagnoses that included: weakness, hypertension, polyneuropathy, hyperlipidemia, and others.</p> <p>The quarterly Minimum Data Set (MDS) dated 05/02/21 indicated that Resident #37 was cognitively intact for daily decision making and required extensive assistance with bathing. The MDS also revealed no rejection of care during the</p>	F 677			

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F 677	<p>Continued From page 64 assessment reference period.</p> <p>The facility's shower schedule revealed that Resident #37 was scheduled for a shower every Tuesday, Thursday, and Saturday in the morning.</p> <p>Resident #37's bathing record dated June 2021 revealed that on Tuesday 06/01/21 Resident #37 received a shower, on Thursday 06/03/21 Resident #37 received a shower, on Saturday 06/05/21 no shower or bath was recorded, on Tuesday 06/08/21 no shower or bath was recorded, on Thursday 06/10/21 no shower or bath was recorded, on Saturday 06/12/21 no shower or bath was recorded, on Tuesday 06/15/21 a shower was recorded, on Thursday 06/17/21 no shower or bath was recorded, on Saturday 06/19/21 no shower or bath was recorded, and on Tuesday 06/22/21 no shower or bath was recorded.</p> <p>An interview was conducted with Resident #37 on 06/21/21 at 10:32 AM. Resident #37 stated that she had agreed upon with the staff to receive a shower three times a week and they were scheduled on Tuesday/Thursday/Saturdays in the morning. She stated that sometimes she would get them during the week but rarely to never got her showers that were scheduled on the weekends. Resident #37 stated that in the past she had been able to complete her showers independently with supervision from the staff for safety but that was not the case now, she physically needed help with washing her body and hair. She explained that most of the time the staff would tell her they did not have enough staff to do her showers or did not have the time to take her to the shower because there was not enough staff.</p>	F 677			

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F 677	<p>Continued From page 65</p> <p>An interview was conducted with Nurse Aide (NA) #6 on 06/23/21 at 10:38 AM. NA #6 confirmed that he cared for Resident #37 a few times but stated he had never showered Resident #37 nor could he recall when her showers were scheduled. NA #6 stated that there was not enough staff to complete all the shower that were scheduled, he added that he stayed over to try and complete all the showers but sometimes that was not possible. NA #6 state that he worked this past weekend on 06/19/21 and confirmed Resident #37 did not get a shower and could not recall why except for there was just not enough staff to do them.</p> <p>An interview was conducted with the Unit Manager (UM) on 06/24/21 at 10:24 AM. The UM stated that she had recently spoken to the residents and obtained their bathing preferences and once she obtained them, she entered them directly into the electronic medical record where the task would populate to the NAs for completion. The UM stated that she did not check the shower book at the nurse's station, but she assumed the shower book aligned with the task in the electronic medical record. The UM stated that she expected the staff to complete the showers per the schedule as per the resident requested.</p> <p>An interview was conducted with the DON on 06/24/21 at 3:58 PM. The DON stated that the UM had went around and spoke to the resident about their bathing preferences but was not sure what she had done with the information she collected because the facility was in the process of switching to 12 hour shifts. The DON stated that whatever the resident decided about their showers was what she expected to happen. The</p>	F 677			

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F 677	<p>Continued From page 66</p> <p>DON explained that 90-95% of the staff they had was agency and that sometimes staffing was "hit or miss" because at times the agency staff would confirm their assignment but then just not show up. The DON stated that they scheduled enough staff but didn't always end up with enough staff.</p> <p>An interview was conducted with NA #4 on 06/24/21 at 6:30 PM. NA #4 confirmed that she cared for Resident #37 at times and was familiar with her care. She stated that she reviewed the shower book at the nurse's station each day to see who was scheduled for a shower. NA #4 stated that it depended on how many NAs they had that day if the residents received their shower or not. She explained that generally there were 3 NAs on the evening shift and that did not leave enough staff to complete showers especially if the resident required 2-person assist. NA #3 explained sometimes someone from first shift would stay over and that would allow the second shift to get some of their showers done but that was not always the case. NA #4 confirmed that she worked on Saturday 06/05/21, Thursday 06/10/21 and Tuesday 06/22/21 and stated if she did not document a shower then she did not give it because there was not enough time to fed the residents, dry them and to complete the showers.</p> <p>4. Resident #17 was admitted to the facility on 02/10/16 with diagnoses that included stroke.</p> <p>A review of Resident #17's most recent quarterly Minimum Data Set Assessment dated 04/14/21 revealed him to be cognitively intact for daily decision making with no documented behaviors or instances of rejected care. Resident #17 was coded as requiring extensive assistance with bed mobility, transfer, dressing, toilet use, and</p>	F 677			

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F 677	<p>Continued From page 67</p> <p>personal hygiene and he required total assistance with bathing.</p> <p>A review of Resident #17's care plan dated 04/26/21 revealed a care plan area for "[Resident #17] has an Activities of Daily Living (ADL) self-care performance deficit related to stroke with hemiplegia, impaired mobility, and weakness." Interventions included "AM routine: prefers breakfast in bed and dressing/grooming routine in AM" and "prefers showers 2 times per week on day shift"</p> <p>A review of Resident #17's bathing sheet for the month of June, 2021 revealed he had received 3 showers for the month. A shower was documented as given on 06/01/21, 06/15/21, and 06/19/21.</p> <p>During an interview with Resident #17 on 06/22/21 at 9:33 AM, he reported he had not received a shower on his scheduled weekend day in the past 7 weeks. He stated he was scheduled to get his showers on Tuesdays and Saturdays. Observation of Resident #17 revealed him to have unkempt hair with a greasy appearance.</p> <p>During an interview with Nurse Aide (NA) #10 on 06/24/21 at 1:42PM, she reported Resident #17 required extensive assistance with bathing due to his limited mobility. NA #10 stated she worked every weekend and that there were times when showers would not be completed due to lack of staffing in the facility. She reported she tried to make sure that showers were done but that with the amount of staff the facility scheduled all she really had time to do was assist residents with eating, changing incontinent residents and turning the dependent residents. She reported when</p>	F 677			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 677	<p>Continued From page 68</p> <p>showers could not be completed due to the workload, she at least gave a bed bath or partial shower.</p> <p>During an interview with NA #7 on 06/24/21 at 12:58, she reported she was familiar with Resident #17 and that he was dependent on staff for completion of his showers. She reported she could not remember if she had been able to give Resident #17 a shower or not when she was working but stated there were times when there were only 2 NAs and 2 Nurses scheduled in the building and when that occurred, showers were not provided because all she could complete was turning dependent residents, changing incontinent residents, and provide assistance with feeding.</p> <p>During an interview with the Director of Nursing on 06/25/21 at 11:55AM, she reported she expected residents to receive showers as scheduled unless they refused. She stated if a resident refused a shower, then it should be appropriately documented. She stated Resident #17 should have received his showers on Tuesdays and Saturdays, in the morning as per his preference.</p> <p>During an interview with the Administrator on 06/25/21 at 2:45PM, he reported he was in the midst of changing his staffing to 12 hour shifts for the NAs and was implementing a dedicated shower team whose sole responsibility would be to provide showers to residents on their assigned days. He reported he expected his staff to provide resident showers as they were scheduled.</p>	F 677			

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F 677	<p>Continued From page 69</p> <p>5. Resident #45 was admitted to the facility on 05/11/21 with diagnoses that included chronic obstructive pulmonary disease (COPD) and lung cancer.</p> <p>The admission Minimum Data Set (MDS) assessment dated 05/18/21 revealed Resident #45 was cognitively intact and required physical help in part of bathing activity with the assistance of one staff. The MDS also indicated Resident #45 was oxygen dependent.</p> <p>A review of Resident #45's care plan dated 05/24/21 revealed she had a self care deficit performance related to the diagnoses of lung cancer and COPD. The goal for the Resident to remain at her current level of functioning in her activities of daily living through the next review would be attained by utilizing interventions that included set up supplies for bathing and transfer assistance of one staff.</p> <p>A review of the 100 Hall shower list revealed Resident #45's room number was not on the shower list.</p> <p>A review of Resident #45's bathing record from 06/09/21 through 06/21/21 revealed only one shower was documented as given on 06/18/21.</p> <p>An interview was conducted with Resident #45 on 06/21/21 at 4:40 PM. The Resident explained that she had only received one shower since she transferred to her current room on 06/09/21. The Resident continued to explain that she had been getting two showers a week on Tuesday and Friday evenings but after 06/09/21 when she transferred to her current room she had only received one shower. Resident #45 stated she</p>	F 677			

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F 677	<p>Continued From page 70</p> <p>was okay with two showers a week but really needed her showers because her hair was oily (Resident pointed to her hair that did appear oily and matted to her head) when it was not washed regularly. The Resident stated that when she asked the nurse aides to assist her with her showers their responses were that they did not have the time, or that she was not on the shower list.</p> <p>An interview was conducted with Nurse Aide (NA) #2 on 06/23/21 at 4:06 PM. The NA confirmed that she worked on Resident #45's hall on 06/15/21 evening shift but did not have time to assist her with her shower due to the workload on the hall.</p> <p>During an interview with Nurse Aide (NA) #8 on 06/23/21 at 5:40 PM she confirmed she assisted Resident #45 with her shower on the evening of 06/18/21. The NA explained that the Resident approached her and asked her if she would let her shower and the NA stated she made time for her.</p> <p>On 06/24/21 at 6:30 PM an interview with Nurse Aide (NA) #4 revealed she remembered Resident #45 asked her to give the Resident a shower one evening (could not remember the evening) but Resident #45 was not on the shower schedule to receive a shower that shift. The NA stated she told Resident #45 that her shower days may have changed since she was moved to a new hall and that the NA did not know what the new shower days would be.</p> <p>Attempts were made to interview the NA who worked on 06/11/21 evening shift but were unsuccessful.</p>	F 677			

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F 677	Continued From page 71 An interview was conducted with the Director of Nursing (DON) on 06/25/21 at 10:30 AM. The DON explained that she had identified that there was no system in place maintaining the shower schedules and management was in the process of updating the shower schedules on 06/21/21 but the audit had to be put off for the time being. Regardless of that the DON stated Resident #45 should have been given a shower when she requested no matter if she was scheduled for one or not. On 06/25/21 at 11:26 AM during an interview with the Administrator he explained that Resident #45 should have received her two showers a week and more if she requested them.	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, resident and staff interviews, the facility failed to provide	F 686	#1 Resident #7 and #210 continue to receive pressure wound dressing changes	7/26/21	

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F 686	<p>Continued From page 72</p> <p>pressure ulcer care according to the physician's order during a pressure ulcer observation for 2 of 2 residents sampled for pressure ulcers (Resident #7 and Resident #210).</p> <p>Findings included:</p> <p>1. Resident #7 was admitted to the facility on 03/09/21 with diagnoses that included ischemic foot and diabetes.</p> <p>A skin care plan dated 5/5/21 included a Stage II pressure ulcer with interventions of administer treatments as ordered.</p> <p>A wound provider note dated 06/11/21 revealed a Stage II pressure ulcer measuring 1.5 centimeter (cm) x 1.5 cm x 0.1 cm with moderate serosanguineous exudate with a sacral treatment order of the following: wound cleaning spray, silver alginate (a wound dressing with an antimicrobial agent to decrease wound infection and collect exudate) , and cover daily.</p> <p>A recent quarterly Minimum Data Set dated 06/16/21 revealed Resident #7 was rarely or never understood and extensive to total dependent for all ADL care. The MDS further indicated Resident #7 had a Stage II pressure ulcer that was not present on admission.</p> <p>An observation of pressure ulcer care on 06/24/21 at 3:20 PM revealed Resident #7 laying on her back in bed with her legs bent back and clinching a triangular wedge towards her buttocks. Nurse #8 entered the room and told Resident #7 she needed to perform wound care therapy to her Stage II pressure ulcer to her sacrum. From the treatment cart outside</p>	F 686	<p>as ordered by the physician and reflected on the Treatment Administration Record (TAR). On 7/26/2021 the DON provided 1:1 education to Nurse #8 on completing wound treatments as ordered by the physician.</p> <p>#2 On 7/26/2021 the DON completed dressing change observations of residents with current pressure wounds to validate treatments are provided as ordered and documented on the TAR. No discrepancies identified.</p> <p>#3 On 7/26/21, the DON completed education to licensed nurses on completing wound treatments as ordered by the physician and documenting administration per the TAR. Newly hired licensed nurses will receive education upon hire.</p> <p>#4 The DON or Nurse supervisor will monitor wound dressing changes and TAR for 5 residents with pressure wounds to ensure treatment as ordered. Monitoring will be completed two (2) times weekly for four (4) weeks, then weekly for eight (8) weeks and as necessary thereafter. The Administrator will report findings of the monitoring to the Interdisciplinary Team (IDT) during</p>		

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F 686	<p>Continued From page 73</p> <p>Resident #7's room, Nurse #8 sat the following supplies on an overbed table: a cloth towel drape, a bottle of cleaning spray, a wooden tongue depressor, 4 x 4 gauze, a bordered gauze dressing, and 2 plastic cups containing 2 substances Nurse #8 had squeezed from two different tubes labeled with Resident #7's name. Nurse #8 labeled the bordered gauze with the date and time of 6/24 3:22 PM and applied clear plastic gloves on each hand and entered the room pushing the bedside table to the bed. Nurse #8 pulled back the sheet that was partially draped over Resident #7's small frame and Nurse #8 then performed PRN pressure ulcer care. She removed a dressing labeled 6/24 9:23 AM. She picked up a cup of cream from the overbed table and applied a thick layer of cream to Resident #7's entire backside. Nurse #8 identified the cream to be an incontinence barrier cream. She then picked up another cup of cream of which she identified as Debriding Ointment #1 (an ointment used to remove impaired tissue) which she used the wooden tongue depressor stick to apply a thick layer of Ointment #1 to the inside of the sacral wound then put the wooden stick back into Ointment #1 and obtained additional ointment and applied it to the intact skin on the outside of the sacrum area of Resident #7. She covered the pressure ulcer with a bordered gauze dressing. She then covered Resident #7 with the sheet on Resident #7's bed and discarded the soiled dressing in the trash before exiting the room. Nurse #8 was not observed to obtain or apply the ordered alginate wound dressing (a dressing used to collect drainage) before applying the bordered gauze outer dressing.</p> <p>An interview on 06/24/21 at 3:38 PM with Nurse #8 revealed she was assigned to complete</p>	F 686			

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F 686	<p>Continued From page 74</p> <p>Resident #7's treatments for the day shift. She indicated she had already changed it earlier in the shift, but staff notified her the pressure ulcer dressing to the sacrum was soiled and needed a PRN (as needed) dressing change. She acknowledged she was nervous while being observed. Nurse #8 said she gathered the supplies by memory and acknowledged she failed to apply the alginate dressing (wound dressing for collection of drainage) ordered to be applied directly over the debriding ointment but she had been trained to follow physician's orders as written and normally would have verified the order from the Treatment Administration Record (TAR) before performing the treatment. Nurse #8 explained she didn't think about the likelihood of the debriding ointment being applied to healthy tissue could cause additional skin breakdown and didn't recall the alginate dressing as part of the order when she gathered the supplies from the treatment cart.</p> <p>An interview on 06/25/21 at 8:30 AM with the Director of Nursing (DON) revealed she expected each staff member to follow a resident's treatment orders as written. She indicated she was unsure if Ointment #1, being a debriding agent, applied to the good intact tissue would harm the skin, how it might effect the wound if the exudate collecting portion of the dressing was not applied, and Nurse #8 should have known to only wear one pair of gloves on at a time and perform hand hygiene when gloves were changed. The DON acknowledged the bordered gauze dressing would not stay in place due to the incontinence barrier cream applied to Resident #7's entire bottom.</p> <p>An interview on 06/25/21 at 9:24 AM with the</p>	F 686			

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F 686	<p>Continued From page 75</p> <p>Nurse Practitioner revealed he felt if the debriding agent was applied to the healthy tissue, it could cause further skin breakdown to the pressure ulcer. He further revealed the wound dressing portion used to collect exudate was needed to aid Ointment #1 stay in place and assist with debriding of the wound bed and was needed to prevent further skin breakdown.</p> <p>2. Resident #210 was admitted to the facility on 10/18/20 with diagnoses that included end stage renal disease, diabetes mellitus with complication, muscle weakness, and Alzheimer's disease. Resident was subsequently discharged on 12/30/20.</p> <p>Review of Resident #210's care plan dated 10/30/20 revealed a care plan for "Resident #210 has potential for pressure ulcer development related to impaired mobility, incontinence, Alzheimer's, anemia, diabetes, and kidney failure. Deep tissue injury to left heel 12/1/20." Interventions included administer treatments as ordered and monitor for effectiveness; assess and document status of wound perimeter, wound bed, and healing progress.</p> <p>Resident #210's physician orders revealed an order dated 12/02/21 for "left heel clean with wound cleanser, pat dry, apply dimethicone (a skin moisturizer), and wrap with kerlix daily and as needed until healed. Every day-shift for wound." On 12/25/20, that order was changed to "left heel clean with wound cleanser, pat dry, apply silver alginate and cover with dry gauze daily and as needed until healed. Every day-shift for wound."</p> <p>Review of wound physician note dated 12/08/20</p>	F 686			

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F 686	<p>Continued From page 76</p> <p>revealed Resident #210 was initially seen due to the development of a deep tissue injury to her left heel that measured 7 centimeters (cm) x 5 cm x 0 cm.</p> <p>Review of an additional wound physician note dated 12/17/20 revealed Resident #210's left heel wound with measurements of 3.5 cm x 1.6 cm x 0.1 cm depth. The wound had a discharge of blood and blood serum with no odor.</p> <p>Resident #210's electronic treatment administration record (TAR) logs from December 2020 revealed no signatures on the TAR for the dates of December 4th-7th, 10th, 13th and 14th, 17th and 18th, 20th, and the 24th for the physician order for daily wound treatment to Resident #210's left heel.</p> <p>Interviews with nurses assigned to Resident #210 on the dates the treatments were not initialed as completed were attempted but unsuccessful.</p> <p>During an interview with the Wound Nurse on 06/25/21 at 10:32AM, she reported she was not working in the facility at the time of Resident #210's admission. She reported she would be unable to determine if wound care was provided based on the TAR record. She reported her understanding was if the TAR was not initialed, then the wound care would not have been completed.</p> <p>An interview with the Director of Nursing on 06/25/21 at 12:35PM revealed although she was not working at the facility at the time of Resident #210's admission she expected wound care to be completed as ordered and signed off on as being completed. She reported based on her review of</p>	F 686			

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F 686	Continued From page 77 Resident #210's TAR, she would assume that the pressure ulcer treatments were not completed. An interview with the Administrator on 06/25/21 at 2:45PM, he reported it was his expectation that a resident's pressure ulcer treatments be completed according to the physician order and documented as completed in on the Treatment Administration Record.	F 686			
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff and residents' interviews the facility failed to assist ambulation for 1 of 1 (Resident #21) and failed to provide splints for 2 of 2 (Residents #13 and #44) reviewed for positioning and mobility services.	F 688	#1 7/21/2021 the DON obtained physician orders for nursing to provide assistance with daily ambulation with walker as tolerated for Resident #21 and updated care plan and nurse aide task list accordingly. On 7/21/2021, the DON	7/26/21	

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F 688	<p>Continued From page 78</p> <p>The findings included:</p> <p>1. Resident #21 was admitted to the facility on 10/07/21 with diagnoses that included arthritis.</p> <p>The quarterly Minimum Data Set (MDS) assessment dated 04/16/21 revealed Resident #21's cognition was moderately intact and had no rejection of care indicated on the MDS. Resident #21 required extensive assistance of one staff for transfers and required limited assistance for locomotion in her room. The MDS also indicated Resident #21's balance was not steady and only able to stabilize with human assistance and used a walker and wheelchair for mobility devices. Resident #21 was also occasionally incontinent of bladder and bowel.</p> <p>A review of Resident #21's care plan revised on 01/29/21 indicated she was at risk for falls related to incontinence, weakness and a history of falls. The goal to be free of major injury would be reached by utilizing interventions that included to ensure she is wearing appropriate footwear when ambulating or mobilizing in the wheelchair and to consult physical therapy for evaluation and treatment as needed. An additional care plan revised 04/29/21 indicated Resident #21 had a self care performance deficit related to arthritis and weakness. The goal to maintain her level of function in eating would be maintained by interventions such as limited assistance with the use of a walker and to encourage ambulation.</p> <p>On 06/21/21/at 12:12 PM an interview was conducted with Resident #21 who explained that she was recently working with skilled physical therapy services and they ambulated her with her walker in the hallway every day but the therapy</p>	F 688	<p>updated Resident #13 and #44 care plan and nurse aide task list to provide splint care as ordered and to increase/prevent decrease in residents ROM/mobility.</p> <p>#2 On 7/26/2021, the DON and Therapy director completed an audit of current residents not on therapy caseload who triggered on 672 for limitations to ensure appropriate orders and plans of care are in place to prevent a decline in resident ROM/mobility. Identified resident orders, care plans and nurse aide task lists updated as appropriate.</p> <p>#3 On 7/26/2021, the DON and Therapy Director provided education to licensed nurses and nurse aides on providing assistance with ambulation and splinting as ordered and per resident plan of care to prevent a decline in resident ROM/mobility. Upon discharge from therapy, the licensed nurse will obtain recommendations from therapy, obtain physician orders, update resident plan of care and nurse aide task list to provide ROM/mobility assistance as necessary.</p> <p>#4 The DON or Nurse supervisor will monitor 5 residents not receiving therapy services for appropriate care to increase/prevent decline in ROM/mobility. Monitoring will be completed two (2) times weekly for four (4) weeks, then weekly for eight (8) weeks and as necessary thereafter. The Administrator will report findings of the monitoring to the Interdisciplinary Team (IDT) during QAPI meetings monthly for three (3) months and will make changes to the plan as necessary to maintain compliance with resident ROM/mobility.</p>		

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F 688	<p>Continued From page 79</p> <p>services had ended about a month ago. The Resident continued to explain that the therapy staff told her that the hall staff would continue with her daily ambulation but she had not been walked since she was released from therapy.</p> <p>A review of Resident #21's medical record revealed an order dated 06/03/21 to discontinue from skilled physical therapy services effective 05/28/21.</p> <p>On 06/23/21 at 10:45 AM an interview was conducted with Nurse Aide (NA) #9. The NA explained that Resident #21 was alert and oriented and was recently released from therapy where she was now more independent than before she started therapy. The NA stated the Resident was able to roll her wheelchair to her destination but that Resident #21 could not ambulate.</p> <p>During an interview with Nurse Aide (NA) #1 on 06/23/21 at 12:39 she explained that Resident #21 was recently on skilled therapy caseload and they ambulated the Resident with her walker in the hallway. The NA stated Resident #21 was no longer on therapy caseload and it was up to the aides to provide the restorative activities after therapy released the residents from skilled therapy if the aides had time to do it. The NA explained that she was aware that Resident #21 had been released from skilled therapy services but that she had not assisted her with ambulation.</p> <p>An interview with Resident #21 on 06/23/21 at 12:55 PM revealed the Resident stated she had not ambulated today and that she had not ambulated since she was released from therapy.</p>	F 688			

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F 688	<p>Continued From page 80</p> <p>During an interview with Nurse Aide (NA) #2 on 06/23/21 at 3:59 PM she explained that Resident #21 was currently on skilled therapy caseload and they ambulated Resident #21. The NA stated nursing staff did not ambulate the residents when they were on skilled therapy caseload but that she pushed Resident #21's wheelchair up to the commode and helped her transfer on to the commode.</p> <p>On 06/24/21 at 4:45 PM during an interview with the Physical Therapist Assistant (PTA) she explained that Resident #21 was recently on skilled physical therapy caseload for ambulation but was released to the hall staff to ambulate with a walker on 05/28/21. The PTA stated she had the Resident on caseload to get her back to her baseline which was ambulating with a walker to the bathroom. The PTA explained that she explained Resident #21's ambulation status to the hall staff when she released her from therapy but knew that Resident #21 was not being ambulated with her walker because her walker was in the same place she left it when she released the Resident from therapy caseload and the Resident's clothing was stored on the walker.</p> <p>An interview was conducted with Nurse Aide (NA) #3 on 06/24/21 at 6:57 PM. The NA explained that Resident #21 was on skilled therapy caseload and they would inform the hall staff when they turned the Resident over to the hall staff to ambulate. The NA stated Resident #21 could ambulate with a walker and she could transfer herself to the commode.</p> <p>During an interview with the Director of Nursing on 06/25/21 at 11:01 AM she explained that the hall staff were responsible for the restorative</p>	F 688			

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F 688	<p>Continued From page 81</p> <p>nursing ambulation and that if the skilled therapy had explained the Resident's ambulation program to the hall staff then she expected the hall staff to ambulate the Resident.</p> <p>An interview was conducted with the Administrator on 06/25/21 at 2:46 PM who explained that the restorative nursing functions such as ambulation was now the responsibility of the hall staff and that if Resident #21 was released from skilled therapy with the direction to ambulate the Resident then he expected it to be done as directed by therapy.</p> <p>2. Resident #13 was admitted to the facility on 04/24/17 with diagnoses that included arthritis.</p> <p>The annual Minimum Data Set (MDS) assessment dated 04/06/21 revealed Resident #13 was cognitively intact had no rejection of care indicated on the MDS. Resident #13 required extensive to total assistance of two staff for most of her activities of daily living. The MDS indicated Resident #13 had functional impairment in range of motion in both upper extremities.</p> <p>A review of a revised care plan dated 05/07/21 revealed Resident #13 had a self care performance deficit related to arthritis and impaired mobility with the goal to maintain her current level of functioning to feed herself by utilizing interventions that included assisting with left hand splint for up to two hours a day as tolerated.</p> <p>A review of Resident #13's medical record dated 05/07/21 revealed a physician order to discontinue Occupational Therapy services as of 05/07/21. There was also a physician order dated</p>	F 688			

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F 688	<p>Continued From page 82</p> <p>05/21/21 for Resident #13 to wear a left hand splint for up to two hours a day as tolerated while up in wheelchair.</p> <p>A review of Resident #13's Kardex (a care guide for the staff) dated 06/23/21 indicated assist with left hand splint for up to two hours a day as tolerated.</p> <p>An interview and observation was conducted with Resident #13 on 06/21/21 at 12:04 PM. The Resident's fingers on both hands were noted to be extended and the Resident demonstrated that she could make a fist with her right hand but not her left hand. She explained that she was working with Occupational Therapy until they released her which was about two months ago and was told that the hall staff would apply a left hand splint daily but the hall staff had never applied the splint. An observation of a picture of Resident #13 wearing a left hand splint was posted on the wall under the television.</p> <p>On 06/23/21 at 10:01 AM an interview was conducted with Nurse Aide (NA) #9. The NA explained that Resident #13 was alert and oriented and could make her needs known. The NA continued to explain that Resident #13 had positioning devices for her legs and feet but not hand splints. She stated that therapy would explain to the hall staff what positioning devices were needed for the residents and would leave the devices in the resident's drawers. The NA stated the hall staff could look at the residents' care plan on the computer to find out if the resident had a positioning device.</p> <p>An interview was conducted with Nurse Aide (NA) #1 on 06/25/21 at 12:08 PM. The NA explained</p>	F 688			

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F 688	<p>Continued From page 83</p> <p>that the nursing staff was supposed to apply the residents' hand splints when they were released from therapy. She continued to explain that Resident #13 told her last week that she was supposed to have a left hand splint but therapy had never told her anything about applying a left hand splint on Resident #13. The NA stated she had never applied a hand splint on Resident #13.</p> <p>An interview with Resident #13 on 06/23/21 at 12:56 PM revealed the Resident stated she has not worn her left hand splint that day.</p> <p>During an interview with Nurse Aide (NA) # 2 on 06/23/21 at 3:35 PM the NA explained she worked mostly on Resident #13's hall and that the Resident did not have hand splints. The NA stated therapy would educate the hall staff on the positioning devices and when to apply them as well as they could look in the computer on the residents' care plan.</p> <p>An interview was conducted with Nurse Aide #5 on 06/24/21 at 1:31 PM. The NA explained that the nursing staff was supposed to perform the restorative functions on the residents that have been released from therapy but the nurses were supposed to let the aides know which resident needed which function. The NA stated Resident #13 asked her to straighten out her fingers when she worked with her over the weekend but that she did not know anything about wearing a splint.</p> <p>An interview was conducted with the Occupational Therapist Assistant (OTA) on 06/24/21 at 5:19 PM. The OTA explained that Resident #13 was released from Occupational Therapy with an order for the staff to apply a left hand splint for up to 2 hours a day and the splint</p>	F 688			

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F 688	<p>Continued From page 84</p> <p>was in the Resident's drawer. She continued to explain that when the Resident was released from therapy she met with the nursing staff and showed them the splint as well as a picture guide that demonstrate how the splint was supposed to be applied and posted the picture on the Resident's board under the television. The OTA stated that she knew that Resident #13 was not wearing her left hand splint as ordered because in the last two weeks she asked the Resident if she had her splint on and the Resident said no.</p> <p>During an interview with the Director of Nursing (DON) on 06/25/21 at 11:01 AM she explained that the hall staff was responsible for the restorative nursing activities that included applying the residents' splints after they had been release from skilled therapies. The DON stated the therapy staff was good about informing the nursing staff about the splinting devices and that if Resident #13 was supposed to be wearing a left hand splint then her expectation was that the nursing staff applied her left hand splint.</p> <p>An interview was conducted with the Administrator on 06/25/21 at 2:46 PM who explained that the restorative nursing functions such as splints was now the responsibility of the hall staff and that if Resident #13 was released from skilled therapy with the direction to wear a left hand splint then he expected it to be done as directed by therapy.</p> <p>An interview with Resident #13 on 06/25/21 at 4:30 PM revealed the Resident stated she had worn her left hand splint that day for over two hours and her left hand did not hurt from not having been wearing the splint.</p>	F 688			

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F 688	<p>Continued From page 85</p> <p>3. Resident #44 was admitted to the facility on 02/06/20 with diagnoses that included stroke, hemiplegia, diabetes, hypertension, and adult failure to thrive.</p> <p>A physician order dated 01/13/21 read, Left elbow and left wrist splint donned 4 to 6 hours per day for contractures. The order was written by the Occupational Therapist (OT).</p> <p>The quarterly Minimum Data Set (MDS) dated 05/14/21 indicated that Resident #44 was cognitively intact for daily decision making and required extensive to total assistance with activities of daily living. No restorative program for splinting was noted during the assessment reference period.</p> <p>An observation and interview were conducted with Resident #44 on 06/21/21 at 4:45 PM. Resident #44 was resting in bed with her eyes open. Resident #44's left elbow was observed contracted as was her left wrist which was inverted almost to the point of the back of her hand touching her left forearm. There was no splint noted to either her left elbow or wrist. Resident #44 stated that occasionally the staff put a splint on her but it no time recently had they applied the splints. When asked if she knew where her splints were at she replied "check in my closet" they might be in there. No splints were observed at Resident #44's bedside or in her closet in her room.</p> <p>An observation of Resident #44 was made on 06/22/21 at 10:40 AM. Resident #44 was resting in bed with her eyes open. No left elbow splint or</p>	F 688			

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F 688	<p>Continued From page 86</p> <p>left wrist splint were observed on the resident or in the resident room.</p> <p>An observation of Resident #44 was made on 06/22/21 at 5:43 PM. Resident #44 was resting in bed with her eyes open. No left elbow splint or left wrist splint were observed on the resident or in the resident room.</p> <p>An observation of Resident #44 was made on 06/23/21 at 8:30 AM. Resident #44 was resting in bed with her eyes open. No left elbow splint or left wrist splint were observed on the resident or in the resident room.</p> <p>An observation of Resident #44 was made on 06/23/21 at 1:00 PM. Resident #44 was resting in bed with her eyes open. No left elbow splint or left wrist splint were observed on the resident or in the resident room.</p> <p>An observation of Resident #44 was made on 06/23/21 at 4:03 PM. Resident #44 was resting in bed with her eyes open. No left elbow splint or left wrist splint were observed on the resident or in the resident room.</p> <p>An interview was conducted with Nurse Aide (NA) #6 on 06/23/21 at 5:08 PM. NA #6 confirmed that he was caring for Resident #44 and stated he did not know anything about any splints and he had never seen Resident #44 wear any splints.</p> <p>An interview was conducted with Nurse #1 on 06/23/21 at 5:11 PM. Nurse #1 stated that she could not recall the last time she saw Resident #44 wear her splints. She stated she was aware that she had splint but could not say why she was not wearing them or again when the last time she</p>	F 688			

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F 688	<p>Continued From page 87 saw them on Resident #44.</p> <p>An interview was conducted with the OT on 06/23/21 at 5:20 PM. The OT stated that she treated Resident #44 in December 2020 to January 2021 and had Resident #44 in 2 extension splints one on her left elbow and one on her left wrist. The OT stated that Resident #44 was tolerating the splints 4-6 hours 5 days a week and never refused to don them. The OT explained the facility had issues with splints not being applied as recommend by therapy and part of that problem was the application of the splints would show up on the nurses documentation and they had to acknowledge whether the splint was on or not but the NAs were actually the ones that were trained to apply them. She explained that the facility was in the process of switching the application of the splints to the NAs, so they had the accountability to put them on and document that. The OT stated that about two months ago the staff were unboxing Resident #44's personal belongings from a room move and they found Resident #44's splint and brought them to the OT. During the room moves the OT explained the education that was posted in Resident #44's room also got misplaced and she was going to have to reprint the education and retrain the staff to apply the left elbow and left wrist splint for Resident #44. The OT stated that the two extension splints helped a little bit for her contractures, but never would they correct or fix her contractures and stated that Resident #44's contractures had not gotten any worse.</p> <p>An observation of Resident #44 was made on 06/24/21 at 10:24 AM. Resident #44 was resting in bed with her eyes open. No left elbow splint or left wrist splint were observed on the resident or</p>	F 688			

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F 688	Continued From page 88 in the resident room. An observation of Resident #44 was made on 06/25/21 at 1:49 PM. Resident #44 was resting in bed with her eyes open. No left elbow splint or left wrist splint were observed on the resident or in the resident room. An interview was conducted with the Director of Nursing (DON) on 06/24/21 at 4:11 PM. The DON stated she was not aware of any issues with Resident #44's splints. She stated that she was aware the OT had educated the staff that would be applying them and then she had signed the form and it was posted in her room. The DON was unaware that Resident #44's splints were not being applied and were in the OT's office and not in the resident room. The DON stated that she expected Resident #44's splint to be applied as ordered and as the staff had been trained to do. An interview was conducted with Administrator on 06/25/21 at 3:28 PM. The Administrator stated he expected Resident #44's splint to be applied as ordered.	F 688			
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:	F 689		7/26/21	

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F 689	<p>Continued From page 89</p> <p>Based on observations, record review, and facility staff and resident interviews, the facility failed to respond to a resident's call light (Resident #23) and after waiting for an hour, the resident got up and ambulated to the bathroom and on the way back to her bed fell, striking her face on the floor and sustaining a hematoma to the left side of her face for 1 of 3 residents reviewed for falls. The facility also failed to safely secure a propane tank on an outdoor grill that was located approximately 3-5 feet of the resident smoking area and was left unlocked and accessible to residents for 1 of 1 smoking areas reviewed, and failed to secure a resident's smoking materials (Resident #31) specifically a lighter, for 1 of 4 residents reviewed that were smokers.</p> <p>Findings Included:</p> <p>1. Resident #23 was admitted to the facility on 03/01/21 with diagnoses that included Parkinson's disease, dementia without behavioral disturbance, psychophysiological insomnia, restless leg syndrome, and edema.</p> <p>A review of Resident #23's most recent quarterly Minimum Data Set Assessment dated 04/16/21 revealed her to be cognitively intact for daily decision making, with no psychosis, behaviors, rejection of care, or instances of wandering. Resident #23 was coded as requiring extensive assistance with bed mobility, transfer, dressing, toilet use, and personal hygiene. Resident #23 was coded as frequently incontinent of bladder and occasionally incontinent of bowel. She was coded as not having had any falls since admission/entry or prior assessment.</p>	F 689	<p>#1 Resident #23 fall d/t call light not answered. Resident call bell to be answered timely. On 6/25/21 Resident #31 smoking material removed from room and stored on nurses cart. On 7/20/21 Resident #31 smoking assessment and care plan updated to reflect supervised smoking. Propane tank was removed on 6/23/21. The cabinets used to secure the propane tanks on the grill had a fastener lock added by 7/26/21. Fire blanket box was removed and replaced on 7/19/21.</p> <p>#2 Residents who smoke were interviewed and room searched with their permission to ensure no smoking material in room or in possession of residents in violation of smoking policy. residents educated on smoking policy by Activities Director. Residents to be educated on smoking policy upon admission. Propane tank should not be left on the grill when it is not actively being used. Propane tank to be stored in maintenance shop when not in use. When grill is in use, propane tank will be secured in locked cabinet on grill. Fire blanket box secured and accessible in smoking area. Newly hired staff will receive education by 7/26/21 and during orientation.</p> <p>#3 The DON or Designee provided education to direct and indirect staff on the residents right to dignity while residing in the facility and the timely, respectful response to call lights by 7/26/21. Call lights will be answered upon finding by direct and indirect care staff in a timely and respectful manner. Call lights will remain illuminated until the resident needs are met by the appropriate staff member.</p>		

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F 689	<p>Continued From page 90</p> <p>Review of Resident #23's care plan dated 05/03/21 revealed a care plan area for "[Resident #23] has an ADL (activity of daily living) self-care performance deficit related to dementia, Parkinson's [disease], and weakness". Interventions included "extensive assist with one staff for bed mobility, transfers, dressing, toileting, bathing, and ambulation with walker with stand-by assist" and encourage the resident to use bell to call for assistance". Another care plan area was noted for "[Resident #23] is high risk for falls related to deconditioning, gait and balance problems, Parkinson's Disease, diabetes, hypertension, weakness, medication use, and fall history". Interventions included: "Anticipate and meet her needs, be sure call light is within reach and encourage to use it for assistance as needed, and educate the resident, family, and caregivers about safety reminders and what to do if a fall occurs".</p> <p>During an interview with Resident #23 on 06/21/21 at 10:56 AM, she reported on 06/07/21 she had pressed her call light after breakfast because she needed to use the restroom. Resident #23 reported after waiting approximately an hour, she decided she was going to try and go to the restroom on her own. She reported she knew it had been an hour because she keeps her phone next to her at all times and monitored how long it had been since she had pressed her light. She reported she got up from her bed while supporting herself on her rolling tray table that beside her bed and then used her "grabber" to drag her rollator over to her. Resident #23 stated she used her rollator to ambulate to the bathroom on her own and when she was returning to her bed from the bathroom, she fell, hitting the left side of her head. She reported she remained on</p>	F 689	<p>Newly hired direct and indirect care staff will receive education during orientation. Administrator educated Maintenance Director on proper use of outdoor grill and securing of propane tank by 7/26/21. Propane tank should not be left on the grill when it is not actively being used. Propane tank to be stored in maintenance shop when not in use. When grill is in use, propane tank will be used per manufacture settings. Fire blanket box secured and accessible in smoking area. Residents who smoke had smoking assessments updated, care plans in place, and educated on smoking policy to include storage of smoking materials in mailboxes or on medication carts and not in resident room by 7/26/21. Administrator educated facility staff educated on smoking policy, to include proper storage and function of fire blanket, securing of propane tank during and in between use, and call bell timeliness by 7/26/21. Newly hired direct and indirect care staff will receive education during orientation.</p> <p>#4 Residents who smoke will be monitored for smoking material in room and grill will be monitored by Maintenance Director or Activities Director to ensure proper storage of propane tank five (5) times weekly for four (4) weeks, then weekly for eight (8) weeks and as necessary thereafter. Department Heads will complete an audit for ten (10) random residents via call bell audit to ensure call bell timeliness is maintained. Monitoring will be completed five (5) times weekly for four (4) weeks, then weekly for eight (8) weeks and as necessary thereafter. The</p>		

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F 689	<p>Continued From page 91</p> <p>the floor calling for assistance for approximately another 30 minutes before nurses entered the room and assisted her.</p> <p>An observation of Resident #23 on 06/21/21 at 10:56 AM revealed dark blue and black bruising to the left side of her face, around her eye and orbital bone and an approximate 1inch abrasion to the left side of her face.</p> <p>A review of the facility provided incident and accident logs revealed Resident #23 was logged as having an unwitnessed fall on 06/07/21. A review of the incident report revealed Resident #23 was noted to be calling out from her room and when the hall nurse arrived, Resident #23 was observed lying in the floor of her room near her bathroom. Resident #23 reported to the nurse that she was coming out of the bathroom when she lost her balance. Per the report, Resident #23's vitals were stable, but a hematoma was noted to the left side of Resident #23's forehead, near the hairline. Resident #23 was assessed and a new order for treatment and x-rays were obtained.</p> <p>Review of Resident #23's electronic physician orders revealed an order dated 06/07/21 for "obtain x-ray of left elbow 2 view and left hip 2 view over recent fall and complaint of pain." A review of the x-ray results revealed no fracture to resident's shoulder or hip.</p> <p>During an interview with Nurse #4 on 06/24/21 at 11:53AM, she reported she was scheduled to work on Resident #23's hall on 06/07/21. She reported when she arrived for her shift slightly before 7:00AM on 06/07/21, Resident #23 was already up and sitting in her wheelchair. She</p>	F 689	Administrator will report findings of the monitoring to the IDT during QAPI meetings monthly for three (3) months and will make changes to the plan as necessary to maintain compliance.		

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F 689	<p>Continued From page 92</p> <p>stated she did not see Resident #23 again until around 8:30AM when she heard her calling out from her room. She reported when she entered the room, she noted Resident #23 to be lying on the floor just outside her bathroom. She stated when she questioned Resident #23 about the fall, she reported she had lost her balance coming from the bathroom. Nurse #4 reported she assessed Resident #23 and noted a "bump" on her forehead. Nurse #4 reported she was aware that Resident #23 was a fall risk but reported Resident #23 had been working with therapy and had become more stable in her ambulation. Nurse #4 reported she did not remember if Resident #23's call light was illuminated when she went in the room or not.</p> <p>An interview with Nurse #5 on 06/24/21 at 2:18PM revealed she was working in the facility on 06/07/21 when Resident #23 fell. She stated that morning was not particularly busy and had just received reports from the off going nurse when she heard resident calling out from her room. She stated she entered the room with Nurse #4 and noted Resident #23 on the floor near her bathroom. She reported they assessed Resident #23 and she observed noticeable swelling to the left side of Resident #23's face. She stated she did not remember if Resident #23's call light was on at the time they entered the room.</p> <p>An interview with NA #7 was attempted on 06/24/21 at 2:42 PM via telephone but was unsuccessful. An additional attempt to speak with NA #7 was attempted on 06/25/21 at 10:14 AM but again, was unsuccessful.</p> <p>During a follow up interview with Resident #23 on</p>	F 689			

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F 689	<p>Continued From page 93</p> <p>06/25/21 at 8:54AM, she reported she actually used three different methods to get the attention of the staff. She reported because the staff routinely ignored her call light, she requested a physical bell which she could ring in addition to the illuminated call light outside her room. She also reported because staff had now started to ignore the audible bell, she had resorted to "hollering until they come". She reported the morning she fell; she only utilized her illuminated call light to call for assistance to the bathroom.</p> <p>Interview with the Director of Nursing on 06/25/21 at 11:43AM revealed she was familiar with Resident #23 and the fall she sustained on 06/07/21. She reported Resident #23 had a history of intermittent use of her call light. She reported residents should not have to resort to the use of three different methods of alerting facility staff of the need for assistance and she expected call lights to be answered within 15 minutes of illumination.</p> <p>During an interview with the Administrator on 06/25/21 he reported call lights should be answered timely and could not answer whether Resident #23 was appropriately supervised to prevent an accident. He stated if she was not a fall risk before the accident, he felt she should be identified as one after the fall.</p> <p>2. A continuous observation was made on 6/22/21 between 4:00 PM and 5:00 PM revealed courtyard area covered with approximately a 20 foot by 20 foot canopy designated for smoking as well as a large portable outdoor kitchen which contained grilling surfaces and a sink on the top surface sitting approximately 18 inches from the canopy. Below the surface of the outdoor kitchen</p>	F 689			

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F 689	<p>Continued From page 94</p> <p>further revealed two cabinets each containing propane tanks with gas lines attached which connected to the ignition switch to enable lighting the grill. The cabinet on the left side contained no locking mechanism and the cabinet on the right included two cabinet doors of which the left door had a broken handle and the right door had a handle with a black combination bicycle lock which was not presently allowing securing of the cabinet's closure. During the observation, the propane tanks were easily accessible. On a wooden bench next to the grill laid a rusted metal box with jagged, sharp edges labeled Emergency Fire Blanket. Inside the box was a gray blanket with tattered and frail edges and rust stains on the surface.</p> <p>An interview on 06/23/21 at 11:42 AM with the Maintenance Director revealed he was familiar with the outdoor courtyard area of the facility. He stated it was for all residents, but it had an area designated for smoking, a gardening area, and an outdoor kitchen which the facility used for events and activities. The Maintenance Director acknowledged the outdoor kitchen contained cabinet regions which held two unsecured propane tanks and he knew the fire blanket was damaged and was not in functional order. He stated he thought the handle became broken during National Nursing Home week in early May of 2021 when it was used by staff for a cookout for residents and staff; however, he explained the lock on the handle had not been used to secure the handles together since he had been employed and he didn't know the padlock code to use to unlock the existing bicycle lock for removal. He could not verify during the interview how much propane was left in each tank. The Maintenance man stated he had been made</p>	F 689			

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F 689	<p>Continued From page 95</p> <p>aware of the damage to the fire blanket and would have the administrator purchase a new one.</p> <p>An interview on 06/23/21 at 12:02 PM with the current Activity's Director revealed she had just taken over in her position but was working in the facility during the time of Nursing Home week. She stated the outdoor grill was used for a cookout, but had not been involved, but believed the former Activity Director assisted with the activities and possibly used the grill.</p> <p>An interview on 06/23/21 at 12:04 PM with the Former Activities Director revealed she was familiar with the outdoor grill and knew it had been used earlier this year during National Nursing Home Week for a cookout. She stated she did not use the grill, but did assist in taking supplies out to the member staff who used the grill to cook hamburgers, hotdogs, and chicken for residents and staff, but could not recall which staff member it was at the time.</p> <p>An interview on 06/23/21 at 2:00 PM with the Director of Nursing (DON) revealed she is familiar with the outdoor kitchen being in the smoking area. She stated the facility had approximately 5 smokers, but the courtyard was used by all residents. The DON indicated she was aware it was used for cookouts and events the facility held for all residents and staff but had not directly used it herself. The DON stated she recalled the outdoor grill being used by the Maintenance Director and Administrator during National Nursing Home Week but verified the doors to the cabinets containing the propane tanks were unsecured with any form of lock. The DON stated was not aware before earlier today that the</p>	F 689			

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F 689	<p>Continued From page 96</p> <p>emergency fire blanket had damage to include rust and shredded damage edges nor that the box had jagged sharp edges on its exterior and explained the blanket needed to be replaced for the safety of the residents in the smoking area. She stated the Administrator had attempted to order one that morning but it would take several days for it to arrive so they had contacted the area Fire Marshall's office which agreed to loan them one until the new one arrived.</p> <p>An interview on 06/25/21 at 4:26 PM with the Administrator revealed he was familiar with the outdoor kitchen in the courtyard which a portion had been designated for smoking. He stated he was unaware the cabinets containing gas lines attached to the propane tanks were unlocked but expected all residents to be kept safe at all times. He also revealed he expected the emergency fire blanket to be functional and properly stored to ensure it could safely be used if necessary.</p> <p>3. Resident #31 was admitted to the facility on 11/13/19 with diagnoses that included cerebral vascular accident (CVA) and dementia.</p> <p>The annual Minimum Data Set (MDS) assessment dated 10/26/20 indicated Resident #31 was a tobacco user.</p> <p>The Safe Smoking Assessment dated 03/25/21 revealed the staff reviewed the policy for storage of smoking materials with Resident #31 and was deemed to be able to smoke independently.</p>	F 689			

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F 689	<p>Continued From page 97</p> <p>The quarterly MDS assessment dated 04/28/21 revealed Resident #31 had severe cognitive impairment.</p> <p>A review of the smoking care plan for Resident #31 had not been updated since 08/20/20 when the Resident was deemed to be an unsafe smoker.</p> <p>On 06/21/21 at 3:52 AM during an interview and observation of Resident #31 he explained that he was an unsupervised smoker and was able to smoke anytime he desired outside. The Resident continued to explain that he kept his smoking material (cigarettes and lighter) in the top drawer of his bedside table. Resident #31 opened the top drawer and pointed to one open pack of cigarettes and 2 lighters laying in the drawer. The Resident stated that he was able to light, smoke and extinguish the cigarette without assistance of staff.</p> <p>An interview was conducted with Nurse Aide (NA) #1 on 06/23/21 at 12:23 PM. The NA explained she was assigned to Resident #31 and stated he was alert and oriented and was an unsupervised smoker and kept his cigarettes and lighter in his room. The NA stated she had reported it to the Nurse that Resident #31 had his smoking materials in his room, but nothing was done about it. The NA continued to explain that the smokers were not allowed to keep their cigarettes and lighter with them in their rooms and the facility provided mailboxes with key locks in the smoking area that they were supposed to utilize for their smoking materials.</p> <p>On 06/23/21 at 1:00 PM a continuous observation was made of Resident #31 exiting his room with</p>	F 689			

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F 689	Continued From page 98 cigarettes and lighter in hand and walked to the designated smoke area outside where he was observed to light the cigarette, smoke and extinguish the cigarette by himself. The Resident then walked back to his room with cigarettes and lighter in hand. On 06/23/21 at 3:45 AM during an interview with Medication Aide #1 she explained that all smokers were supposed to leave their smoking materials on the medication carts and the nurse or medication aide gave the smoking materials to the residents when they went out to smoke. The MA stated she knew that Resident #31 kept his cigarettes and lighter in his room and thought he was allowed to keep them in his room. During an interview with the Director of Nursing (DON) on 06/25/21 at 10:28 AM she explained that the residents, whether they were deemed to be safe or unsafe smokers, were not allowed to keep their smoking materials in their rooms. The DON stated the smoking materials were supposed to be kept on the medication carts. An interview was conducted with the Administrator on 06/25/21 at 11:28 AM. He explained that the residents who smoked, both supervised and unsupervised, were not allowed to keep their smoking materials in their room. He continued to explain that the facility provided locked mailboxes in the smoking area for the residents to store their smoking materials.	F 689			
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes,	F 693			7/26/21

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F 693	<p>Continued From page 99</p> <p>both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-</p> <p>§483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and</p> <p>§483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by:</p> <p>Based observations, record review, staff, Registered Dietitian, and Nurse Practitioner interviews the facility failed to provide tube feeding as ordered by the physician for 1 of 2 residents that required tube feeding (Resident #44).</p> <p>The findings included:</p> <p>Resident #44 was admitted to the facility on 02/06/20 with diagnoses that included stroke, hemiplegia, diabetes, dysphasia, hypertension, and adult failure to thrive.</p> <p>A physician order dated 01/21/21 read, Jevity (enteral feeding) 1.5 per tube continuously via pump at 45 milliliters (ml) per hour (hr) with 55 ml</p>	F 693	<p>#1 7/26/2021, DON provided education to nurse on enteral feedings on following orders on enteral feeding as prescribe by physician.</p> <p>#2 On 7/26/2021, DON/Designee will audit all internal feeding all current enteral feeding for dosing accuracy as indicated by MD order. On Date, DON/Designee will educate all nursing staff on enteral feeding</p> <p>#3 7/26/2021, DON/Designee provided education to licensed nurses for following physician orders for enteral feeding. Newly hired licensed nurses and medication aides will receive education during orientation.</p> <p>#4 DON/Designee will audit all current</p>		

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F 693	<p>Continued From page 100 water flush.</p> <p>The quarterly Minimum Data Set (MDS) dated 05/14/21 indicated that Resident #44 was cognitively intact for daily decision making and required extensive to total assistance with activities of daily living. The MDS further indicated that Resident #44 had a feeding tube and received 51% or more of her daily calories via her tube. No weight gain or loss was noted during the observation period.</p> <p>An observation of Resident #44 was made on 06/21/21 at 3:50 PM. Resident #44 was resting in bed with her eyes closed. Her head of bed was elevated approximately 30 degrees. She was observed to have a tube feeding pump that was infusing Jevity 1.5 at 50 ml/hr.</p> <p>An observation and interview were conducted with Resident #44 on 06/21/21 at 4:45 PM. Resident #44 was resting in bed with her eyes open and her head of bed elevated at approximately 30 degree's. She was very soft spoken and had a wet voice quality when she spoke. Resident #44 stated that she had a stroke and was not able to swallow anything and was fed only through her feeding tube. Resident #44 stated she was not sure what rate they fed her at but stated "the nurses take care of that for me." She was observed to have a feeding tube that was connected to the pump next to her bed that was infusing Jevity 1.5 at 50 ml/her.</p> <p>An observation of Resident #44 was made on 06/22/21 at 8:55 AM. Resident #44 was resting in bed with her eyes closed her head of bed was elevated approximately 30 degrees. She was noted to be connected to feeding pump sitting</p>	F 693	<p>enteral feeding residents for accuracy daily X2weeks, twice a week X2 weeks, once week X2 weeks. The administrator will report finding of monitoring to the IDT during QAPI meetings monthly for three (3) months and will make changes to the plan as necessary to maintain compliance with residents right to reasonable accommodations of needs.</p>		

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F 693	<p>Continued From page 101</p> <p>next to her bed which was set to deliver Jevity 1.5 at 50 ml/hr.</p> <p>An interview was conducted with Nurse #2 on 06/24/21 at 12:16 PM. Nurse #2 confirmed that she was caring for Resident #44 on 06/22/21. She stated that when she was making her first round on her medication pass that morning she went into Resident #44's room and discovered that the shift before had not changed out the syringe and her formula was about to expire so while she was switching out the formula she noticed that the rate was incorrect. Nurse #2 stated that once she had changed the equipment out and hung a new bottle of Jevity 1.5 she corrected the rate to 45 ml/hr. She stated she was not sure how long the rate was infusing at 50 cc/hr but stated her ordered rate was 45 cc/hr so she placed the pump at the correct rate.</p> <p>An interview was conducted with the Registered Dietitian (RD) on 06/25/21 at 8:25 AM. The RD stated the medical providers would be setting Resident #44's tube feeding rates and water flushes. The RD stated that once the medial providers set the rate the staff should be ensuring that the correct feeding at the correct rate was being administered to the resident.</p> <p>An interview was conducted with the NP on 06/25/21 at 9:30 AM. The NP explained he had been at the facility for a couple of months and was still learning each of the patients. The NP could not speak to Resident #44's tube feeding rate but stated that if there was on order for Jevity 1.5 at 45 ml/hr then the expectation was that she received Jevity 1.5 at 45 ml/hr. The NP explained giving her more than ordered could increase her risk of aspiration.</p>	F 693			

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F 693	Continued From page 102 An interview was conducted with the Director of Nursing (DON) on 06/24/21 at 4:20 PM. The DON stated that when you have a physician order for a tube feeding rate you cannot change the rate without the physician making the change. The DON stated she expected Resident #44's tube feeding rate to be 45 ml/hr as ordered by the physician. An interview was conducted with the Administrator on 06/25/21 at 3:28 PM. The Administrator stated he expected the tube feeding to be administered as ordered by the physician.	F 693			
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff and resident interviews the facility failed to administer oxygen at the prescribed rate for 1 of 1 resident (Resident #45) reviewed for respiratory care. The finding included: Resident #45 was admitted to the facility on 05/11/21 with diagnoses that included chronic obstructive pulmonary disease (COPD) and lung	F 695	#1 7/26/2021 DON/Designee provided education to nurse on oxygen therapy and following orders on oxygen therapy. #2 On7/26/2021, DON/Designee will audit all oxygen orders all current oxygen orders for accuracy as indicated by MD order. On Date DON/Designee will educate all nursing staff on oxygen orders. #3 7/26/2021, DON/Designee provided	7/26/21	

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F 695	<p>Continued From page 103 cancer.</p> <p>A review of Resident #45's medical record revealed a physician order dated 05/13/21 for oxygen to be delivered at 4 liters per minute (l/m).</p> <p>The admission Minimum Data Set assessment dated 05/18/21 revealed Resident #45 was cognitively intact and received oxygen.</p> <p>A review of Resident #45's revised care plan dated 05/21/21 revealed the Resident had respiratory difficulty related to COPD and lung cancer with the goal that she would have no signs or symptoms of poor oxygen absorption through the next review. The interventions included administering oxygen at the prescribed rate.</p> <p>During an observation and interview with Resident #45 on 06/21/21 at 5:05 PM the oxygen concentrator was set at 3 l/m.</p> <p>The Resident explained she never adjusted the setting on her oxygen concentrator but she did adjust the setting on the oxygen tank that was connected to the walker rollator.</p> <p>On 06/23/21 at 10:36 AM during an interview with Nurse Aide #9 she explained that the nurse aides were not allowed to adjust the residents' oxygen settings on the concentrators or the tanks.</p> <p>An observation made on 06/23/21 at 1:22 PM Resident #45's oxygen concentrator setting set at 3 l/m.</p> <p>An interview was conducted with Medication Aide (MA) #1 on 06/23/21 at 3:40 PM. The MA</p>	F 695	<p>education to all licensed nurses for following MD orders for oxygen therapy. #4 DON/Designee will audit all current residents for accuracy of oxygen therapy daily for two (2) weeks, twice a week for two (2) weeks, then weekly for eight (8) weeks and as necessary thereafter. The administrator will report finding of monitoring to the IDT during QAPI meetings monthly for three (3) months and will make changes to the plan as necessary to maintain compliance with administration of oxygen therapy.</p>		

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F 695	<p>Continued From page 104</p> <p>confirmed she worked on 06/21/21 from 7:00 AM to 7:00 PM and stated she checked the oxygen settings during her morning medication pass. The MA explained that Resident #45's oxygen setting was at 4 l/m and she had already checked the setting that day. An observation was made of the oxygen concentrator setting with the MA at 3 l/m and the MA stated she must have looked at the oxygen setting wrong.</p> <p>Attempts were made to interview the Nurse who worked on 06/21/21 and 06/22/21 on the 7:00 PM to 7:00 AM shifts but were unsuccessful.</p> <p>An interview was conducted with Nurse #2 on 06/24/21 at 12:15 PM. The Nurse confirmed that she worked on 06/22/21 from 7:00 AM to 7:00 PM. The Nurse explained that Resident #45's oxygen setting was supposed to be at 4 l/m in which she checked it at anytime during her shifts. When the Nurse was informed that the oxygen concentrator had been set at 3 l/m since 06/21/21 the Nurse replied that she did not check the oxygen concentrator but checked the oxygen tank on the roller walker because that was the one Resident #45 was using when she checked the setting.</p> <p>During an interview with the Director of Nursing (DON) on 06/25/21 at 10:30 AM she explained her expectation was that the nurse or medication aide on Resident #45's hall should be checking for the appropriate oxygen setting for both the oxygen concentrator and tank every shift.</p> <p>An interview was conducted with the Administrator on 06/25/21 at 11:23 AM. The Administrator stated his expectation was that the nursing staff ensure Resident #45's oxygen</p>	F 695			

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F 695	Continued From page 105	F 695			
F 725 SS=E	<p>Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2)</p> <p>§483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).</p> <p>§483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides.</p> <p>§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, and staff interview this facility failed to provide sufficient nursing staff to honor a resident choice of getting out of bed every day, to provide incontinent care and showers as scheduled, and</p>	F 725	#1 Resident #13 to continue to get out of bed per preference. Resident #7 should continue to receive incontinence care as indicated. Residents #24, #37, #17, #4 continue to be showered per their	7/26/21	

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F 725	<p>Continued From page 106</p> <p>to answer call lights in a timely manner for 7 of 11 residents reviewed for staffing.</p> <p>The findings included:</p> <p>This tag is cross referred to:</p> <p>1. F561: Based on staff and Resident interviews, the facility failed to honor Resident #13's choice of getting out of bed every day for 1 of 7 residents reviewed for choices.</p> <p>2. F677: Based on observations, record review, resident and staff interview the facility failed to perform routine incontinent care (Resident #7) and failed to provide scheduled showers (Resident #24, Resident #37, Resident #17, and Resident #45) for 5 of 10 residents reviewed for activities of daily living.</p> <p>3. F689: Based on observations, record review, and facility staff and resident interviews, the facility failed to respond to a resident's call light (Resident #23) and after waiting for an hour, the resident got up and ambulated to the bathroom and on the way back to her bed fell, striking her face on the floor and sustaining a hematoma to the left side of her face for 1 of 3 residents reviewed for falls. The facility also failed to safely secure a propane tank on an outdoor grill that was located approximately 3-5 feet of the resident smoking area and was left unlocked and accessible to residents for 1 of 1 smoking areas reviewed, and failed to secure a resident's smoking materials (Resident #31) specifically a lighter, for 1 of 4 residents reviewed that were smokers.</p> <p>An interview was conducted with Nurse #2 on</p>	F 725	<p>preference. Resident #23 continues to have call bell answered timely.</p> <p>#2 On 6/29/21 completed an audit of interviewable residents via resident questionnaire to ensure residents preferences are being met, call bell answered timely, incontinence care given as indicated. Preferences were updated per resident's requests.</p> <p>#3 Nurse and CNA assignments will be reviewed and adjusted as necessary to better meet the needs of each resident. Shower Schedule grid was updated with resident preferences. DON and/or Unit Manager to verify showers completed daily using shower schedule grid and assignment sheet. CNA and Nursing schedules were changed on 6/27/21 to better meet the needs of the residents. Department Heads round five (5) per week to ensure resident grievances are addressed and resolved, showers received per their preference, call bells answered timely, and incontinence care given as needed. Manager on Duty will round Saturdays and Sundays ensure resident grievances are addressed and resolved, showers received per their preference, call bells answered timely, and incontinence care given as needed. The Director of Social Service or designee will interview 3 alert and oriented residents per week for 4 weeks to ensure their needs have been met. Concerns or issues will be addressed immediately to a supervisor for immediate correction and reviewed at the next stand up meeting. Quality Assurance (QA) Committee members are present at the morning</p>		

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F 725	<p>Continued From page 107</p> <p>06/22/21 at 7:30 AM. Nurse #2 stated that during the day shift they may have enough staff to do incontinence rounds 3 times and even understaffed they did try to complete the scheduled showers except for on the weekends and there was not enough staff to do them.</p> <p>Nurse #6 was interviewed on 06/22/21 at 7:35 AM. Nurse #6 stated that she had worked at the facility for 2 months and staffing was a huge concern because most of the days she worked there were only 3 Nurse Aides (NA) on day shift for 50-60 residents and most resident were provided incontinence care only one time per shift and rarely received their showers as scheduled.</p> <p>NA #9 was interviewed on 06/22/21 at 7:45 AM. NA #9 stated that she worked 4 days a week from a local staffing agency. She stated that staffing was "rough" because most of the time the only thing that the staff had time to do was provide incontinent care to the resident and get them out of bed before the end of her shift. If the staff were lucky, they would have enough time to do another incontinent round around lunch time but most days not everyone got changed before lunch and they had no time to complete their scheduled showers. NA #9 stated that sometime the food was cold by the time they got around to serving it to the residents.</p> <p>NA #4 was interviewed on 06/23/21 at 11:10 AM. NA #4 stated that the only thing she had time to do when she came to work for her scheduled shift which was usually second shift was to pass out the supper trays, pick them up and then put the residents to bed. She stated that at times no one would be assigned to a unit in the facility and she would help answer call lights on that unit during</p>	F 725	<p>meetings. Concerns or issues will be presented to the Quality Assurance (QA) Committee quarterly times 2 quarters.</p> <p>#4 The Administrator will report findings of the monitoring to the IDT during QAPI meetings monthly for three (3) months and will make changes to the plan as necessary to maintain compliance.</p>		

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F 725	<p>Continued From page 108</p> <p>the time that no one was assigned to that unit.</p> <p>A resident council meeting was held with 12 residents on 06/23/21 at 1:30 PM. The council expressed concerns with call bells not being answered in a timely manner because there was not enough staff to help provide the care.</p> <p>The Director of Nursing (DON) was interviewed on 06/24/21 at 2:00 PM. The DON stated that she was aware of the staffing challenges. She stated she tired to schedule 4 NAs as directed by the facility. She explained the facility believed that for a census of 58 4 NAs were sufficient staff. The DON stated she did not feel like that was always enough staff to meet the care needs of all the residents every day.</p> <p>An interview was conducted with the Scheduler on 06/24/21 at 2:33 PM. The Scheduler stated that 90% of the staff in the facility were agency staff and that a big problem with that was that she would confirm with the agency that the staff member was going to come for a scheduled shift and then that employee would not show up. The Scheduler stated that she was taught that on first shift the Nurse Aides (NA) should have no more then 12 residents to care for, second shift NAs should have no more than 15 residents to care for and third shift NAs should have no more then 25 residents to care for. She explained she would take the amount of staff and divide that by the census and that would tell her how many staff members she needed to schedule. The Scheduler further explained that the second shift was the biggest concern and the facility was moving to 12 hour shifts to eliminate the second shift gap and continue to rotate weekends which was another issue because she had one</p>	F 725			

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F 725	<p>Continued From page 109</p> <p>weekend that was over staffed and one weekend that was very short staffed and she had asked some of the staff to switch weekends but they did not want too. She stated that if the staff were aware that they were going to be short on a particular shift they would call out just to avoid having to work with a higher patient load. The Scheduler stated that if an agency employee called out two times then they were not allowed to return to the facility but again she was so dependent on agency staff that she really could not be picky because she was short approximately 8 nurses and approximately 8-10 NAs. She explained in a 24-hour period she may have 6 staff members that were employed by the facility and the rest were agency. Applications were printed off by the Administrator and given to the Scheduler to conduct interviews and make hiring selections but a lot of interviews that are set up the potential employee won ' t show up. She stated that on a daily basis she begs the staff to stay over and work longer hours and to come in on their days off and they get tired of it and want a break but we have to have staff. She added that sometimes the Administrative staff would help pass meal trays and if they were also NAs they would help on the floor when they could.</p> <p>The Administrator was interviewed on 06/25/21 at 3:41 PM. The Administrator stated that his expectation was the ratio of resident to staff was 8-12 residents to 1 NA and they facility tried to schedule that. He stated that we had too much staff at night, but the evening shift was lacking so he indicated he eliminated the evening shift and was going to 12 hours shifts. He indicated that he built a schedule for a census up to 70 residents and we are actively trying to fill those spots. He added that he had reached out to the corporation</p>	F 725			

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F 725	Continued From page 110 and let them know that the local agencies were not giving us the number of staff we needed. The Administrator stated that we have done the best we could to bring staff in, an effort was made but we did best we could.	F 725			
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff, and Nurse Practitioner interview the facility failed to maintain a medication error rate less than 5% when a nurse prepared and administered the wrong medication (Nurse #4) and another nurse (Nurse #5)administered the wrong dose of a medication. There were 3 errors out of 30 opportunities which affected 2 of 4 residents (Resident #1 and Resident #43) observed during medication pass. The findings included: 1. Resident #1 was readmitted to the facility on 05/11/21 with diagnoses that included anemia, acute respiratory failure, and chronic obstructive pulmonary disease. A physician order dated 05/12/21 read for Resident #1, Saccharomyces boulardii (Probiotic) 250 mg give one capsule by mouth three times a day for Probiotic.	F 759	#1 On 6/23/2021 Nurse #4 and on 6/24/2021 Nurse#5 had medications errors, notification to responsibility party and Physician made. Administer medications as prescribe by Physician. #2 On 7/26/2021, DON completed a medication administer observation during morning medication pass to validate administration medications as ordered by physician. No discrepancies were observer. #3 DON/Designee provided education to all license nurses on administration medications as prescribe by physician. License nurses will validate correct medication per physician order to ensure accuracy of medication as prescribed. Newly hired licensed nurses and medication aides will receive education during orientation. #4 DON/Designee will observe medication pass randomly on one (1) resident three (3) times weekly for four (4)	7/26/21	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345179	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/25/2021
NAME OF PROVIDER OR SUPPLIER ACCORDIUS HEALTH AT MOORESVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 752 E CENTER AVENUE MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 759	<p>Continued From page 111</p> <p>A physician order dated 06/04/21 read for Resident #1, Guaifenesin (expectorant) 200 milligrams give 3 tablets by mouth one time a day related to acute respiratory failure with hypoxia.</p> <p>The quarterly Minimum Data Set (MDS) dated 06/05/21 revealed that Resident #1 was severely cognitively impaired for daily decision making and required extensive to total assistance with activities of daily living.</p> <p>An observation of Nurse #4 was made on 06/23/21 at 9:01 AM preparing Resident #1's medications. The medications prepared by Nurse #4 included Mucinex DM (dextromethorphan (cough suppressant)/guaifenesin) 600 mg by mouth 1 tablet and Ferric (iron) 150 mg 1 tablet. After preparing the rest of Resident #1's medications Nurse #4 locked the medication cart and proceed to Resident #1's room and administered the medications that she had prepared. Once administered she returned to the medication cart and documented that she had administered the saccharomyces boulardii and guaifenesin.</p> <p>Nurse #4 was interviewed on 06/24/21 at 10:16 AM. Nurse #4 stated that on 06/23/21 when she was preparing Resident #1's medication she was nervous because that was her first day working in the facility and did not realize that the facility had house stock guaifenesin and when she saw the Mucinex DM she assumed that was what they were using for Resident #1. Nurse #4 continued to state that when she looked at the bottle of Ferric under neath the name it contained the word saccharomyces and she assumed it was the same drug but has since learned it was not. She confirmed that she gave the Ferric which</p>	F 759	<p>weeks, then weekly for eight (8) weeks and as necessary thereafter. The Administrator will report findings of the monitoring to the Interdisciplinary Team (IDT) during QAPI meetings monthly for three (3) months and will make changes to the plan as necessary to maintain compliance with medication administration.</p>		

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F 759	<p>Continued From page 112</p> <p>was iron in place of the saccharomyces boulardii that was ordered and the gave the Mucinex DM in place of the guaifenesin.</p> <p>An interview was conducted with the Nurse Practitioner (NP) on 06/25/21 at 9:30 AM. The NP stated that Resident #1 recently had pneumonia and sepsis and was quadriplegic and suffered from muscularity issues and he avoided using Mucinex DM at all because of the possibility of the release of neuro chemicals which could be detrimental to Resident #1. The NP went on to say that Resident #1's kidneys would filter out the iron that he did not need, and the only real possible side effect would be black stool and may an increase in constipation. He added that he had not yet been made aware of the errors but stated that he would assess Resident #1 to ensure no ill effects were noted. The NP stated that he worked hard at ensuring his orders were easily able to be carried out by the nursing staff and he expected them to follow the orders that were prescribed.</p> <p>An interview was conducted with the Director of Nursing (DON) on 06/24/21 at 4:36 PM. The DON stated that she expected the nurses to administer medication using the 5 rights of medication administration which include the right medication, to the right person, at the right dose, via the correct route, at the correct time each and every time they administered a medication.</p> <p>An interview was conducted with the Administrator on 06/25/21 at 3:40 PM. The Administrator stated that he expected perfection out of the medication pass and expected them to give the correct medication and the correct dose to the resident.</p>	F 759			

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F 759	<p>Continued From page 113</p> <p>2. Resident #43 was admitted to the facility on 10/24/20 and most recently readmitted on 03/13/21 with diagnoses that included gas pain and diarrhea.</p> <p>Review of the quarterly Minimum Data Set (MDS) dated 05/18/21 revealed that Resident #43 was cognitively intact for daily decision making and required extensive to total assistance with activities of daily living.</p> <p>A physician order dated 06/18/21 read; Simethicone tablet 125 milligram give 1 tablet by mouth three times a day related to gas pain.</p> <p>An observation of Nurse #5 preparing Resident #43 medication was made on 06/24/21 at 8:32 AM. Nurse #5 was observed to prepare and place Simethicone 80 mg into a medicine cup along with Resident #43's other medication. Once she had finished preparing all of Resident #43's medication she locked the medication cart and proceeded to Resident #43's room. Once Resident #43 had taken her medication, Nurse #5 returned to the medication cart to document the medication administration.</p> <p>An interview was conducted with Nurse #5 on 06/24/21 at 10:21 PM. Nurse #5 stated that she assumed the simethicone that was on the medication cart was what Resident #43 was supposed to get. Nurse #5 stated that she would have to ask the central supply clerk if he could order the correct dose of simethicone.</p> <p>The Nurse Practitioner (NP) was interviewed on 06/25/21 at 9:30 AM. The NP stated that the dose that Nurse #5 administered to Resident #43 was not the therapeutic dose he was hoping for. He</p>	F 759			

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F 759	Continued From page 114 stated that he ordered the 125 mg of Simethicone because he contacted the pharmacy and they stated that was the dose that they stocked so he thought he was making it easier on the nursing staff. The NP explained that Resident #43 had a chronic ileus causing liquid stools and gas issues. The gas was causing Resident #43 some bloating issues and they were very uncomfortable for the resident which is why he wanted the Simethicone ordered routinely and not as needed to try and keep Resident #43 comfortable. An interview was conducted with the Director of Nursing (DON) on 06/24/21 at 4:36 PM. The DON stated that she expected the nurses to administer medication using the 5 rights of medication administration which include the right medication, to the right person, at the right dose, via the correct route, at the correct time each and every time they administered a medication. An interview was conducted with the Administrator on 06/25/21 at 3:40 PM. The Administrator stated that he expected perfection out of the medication pass and expected them to give the correct medication and the correct dose the resident.	F 759			
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761		7/26/21	

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F 761	<p>Continued From page 115</p> <p>§483.45(h) Storage of Drugs and Biologicals</p> <p>§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.</p> <p>§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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, record review, and staff interview the facility failed to remove expired medication from 2 of 5 medication carts (Medication Cart 200/300 and Medication Cart 300) and failed to remove expired medication from 2 of 2 medication rooms (Medication Room A and Medication Room B). The facility also failed to store controlled substances in a permanently affixed compartment of the refrigerator in 1 of 2 medication rooms (Medication Room A) and failed to secure prepared medications that were left on top of 1 of 5 medication carts (Medication Cart 200/300).</p> <p>The findings included:</p> <p>1 a. An observation of Medication Cart 200/300 along with Nurse #4 was conducted on 06/23/21 at 2:22 PM. The observation revealed the following expired medication that were on the</p>	F 761	<p>#1 On 6/25/2021 expire medications were found in medication carts and medication rooms.</p> <p>#2 On 6/25/21 DON/Designee completed audit of all medication carts and medication rooms . All expired medications found in medication carts and medication rooms were disposed of. On 6/24/21 box containing controlled substances in medication refrigerator was permanently affixed to refrigerator by Maintenance Director.</p> <p>#3 DON/Designee provided education to licensed nurses on Medication Pass and Discontinued Medications policy by 7/26/21. Newly hired licensed nurses and medication aides will receive education Medication Pass and Discontinued Medications policy by</p>		

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F 761	<p>Continued From page 116</p> <p>medication cart and available for use: Allopurinol (treat Gout) 100 milligrams (mg) 19 tablets that expired on 05/31/21, Rosuvastatin (lower cholesterol) 20 mg 10 tablets that expired on 04/30/21 and Loperamide (antidiarrheal) 2 mg 29 tablets that expired on 05/31/21.</p> <p>Nurse #4 was interviewed on 06/23/21 at 2:25 PM. Nurse #4 stated that this was her first day on Medication Cart 200/300 and she did not go through the medication cart looking for expired medication. Nurse #4 stated that third shift primarily went through the medication carts, but all nurses should be making sure no medications they administer were expired. Nurse #4 stated that the 3 medications had been discontinued and were not given.</p> <p>1 b. An observation of Medication Cart 300 along with Nurse #1 was conducted on 06/23/21 at 3:01 PM. The observation revealed the following expired medications were on the medication cart and available for use: Febuxostat (treat gout) 40 mg 20 tablets that expired 06/21/21 and Meclizine (antiemetic) 25 mg 22 tablets that expired on 06/17/21.</p> <p>An interview was conducted with Nurse #1 on 06/23/21 at 3:19 PM. Nurse #1 stated that she had not gone through the medication cart that day but all nurses were supposed to help out by going through the medication carts and removing any expired or discontinued medication. Nurse #1 stated that those medications must have been missed by the staff who had gone through the medication cart.</p> <p>A1c. An observation of Medication Room A was conducted along with Nurse #1 on 06/23/21 at</p>	F 761	<p>7/26/21 and upon hire during orientation.</p> <p>#4 DON/Designee will do an audit of medication carts and medication rooms randomly to find any expired medication three (3) times weekly for four (4) weeks, then weekly for eight (8) weeks and as necessary thereafter. The Administrator will report findings of the monitoring to the Interdisciplinary Team (IDT) during QAPI meetings monthly for three (3) months and will make changes to the plan as necessary to maintain compliance with medication administration</p>		

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F 761	<p>Continued From page 117</p> <p>3:21 PM. The following medication was on the stock shelf and available for use: one unopened bottle of Optic vites with Luten that expired on 03/21.</p> <p>An interview with Nurse #1 was conducted on 06/23/21 at 3:30 PM. Nurse #1 was not sure who was responsible for checking the medication rooms for expired medication but stated that if the nurse came in the medication room and grabbed a bottle of medication, they should be checking the expiration date before opening the bottle of medication.</p> <p>1d. An observation of Medication Room B was conducted along with Nurse #1 on 06/23/21 at 3:09 PM. The following medication was on the stock shelf and available for use: 3 unopened bottles of baby aspirin 81 mg that expired 3/21.</p> <p>An interview with Nurse #1 was conducted on 06/23/21 at 3:30 PM. Nurse #1 was not sure who was responsible for checking the medication rooms for expired medication but stated that if the nurse came in the medication room and grabbed a bottle of medication, they should be checking the expiration date before opening the bottle of medication.</p> <p>An interview was conducted with the Director of Nursing (DON) on 06/24/21 at 4:27 PM. The DON stated that the third shift staff were expected to go through the medication carts and medication rooms at least weekly and remove any expired medication from them. The DON stated that she expected all nurses to check the medications that they administer and be sure they were not expired. She added the expired medication should have been removed from the medication</p>	F 761			

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F 761	<p>Continued From page 118</p> <p>carts and medication rooms and returned to the pharmacy per the facility policy.</p> <p>An interview was conducted with the Administrator on 06/25/31 at 3:38 PM. The Administrator stated that he expected all expired medication to be remove from the medication carts and medication rooms and returned to the pharmacy per their policy.</p> <p>2. An observation of Medication Room A was made on 06/24/21 at 5:45 PM with Nurse #1. Medication Room A contained shelves of house stock medication and a refrigerator that was locked. Nurse #1 obtained the key to the refrigerator and opened the door. There was a small black box that had a silver handle on it located on one of the refrigerator shelves. Nurse #1 picked up the handle and removed the black metal box and sat it on the counter. The black metal box was locked, and Nurse #1 obtained the key and unlocked the box. The black box contained the following: Dronabinol (used for anorexia) 2.5 milligrams (mg) 14 tablets which is a Schedule III narcotic, 7 vials of Ativan (antianxiety medication) which is Schedule IV narcotic, and 3 bottles of Ativan 2mg/milliliter (ml) which is a Schedule IV narcotic.</p> <p>An interview was conducted with Nurse #1 on 06/24/21 at 6:00 PM. Nurse #1 stated that the medications in that box were counted each shift by the nurse that was responsible for that patient. She stated that she since she had been working at the facility that box had always been kept in that refrigerator and was always locked but had never been permanently affixed to the refrigerator that she was aware of.</p>	F 761			

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F 761	<p>Continued From page 119</p> <p>An interview was conducted with the Director of Nursing (DON) on 06/25/21 at 4:27 PM. The DON stated that she was aware that the lock box that was used to store narcotics in the refrigerator was required to be permanently affixed and she reported that to the Administrator and he added a lock to the refrigerator. The DON stated that the lock box contained narcotic and should be permanently affixed to the refrigerator.</p> <p>An interview was conducted with the Administrator on 06/25/21 at 5:00 PM. The Administrator confirmed that he had added a lock to the refrigerator in Medication Room A. He also stated that it was an easy fix and he had already permanently affixed the lock box to the refrigerator.</p> <p>3. An observation of Nurse #4 preparing medications for administration on Medication Cart 200/300 was made on 06/23/21 at 9:27 AM. The medications included: Aspirin 81 milligrams (mg), Mucinex DM (expectorant/cough suppressant) 600 mg, Vitamin D (vitamin) 1000 units, Xifaxan (treat diarrhea) 550 mg, Oxybutynin (antispasmodic) 5 mg, Gabapentin (neuropathy) 300 mg (3 tablets), Depakote (mood stabilizer) 125 mg (4 capsules), Baclofen (muscle relaxer) 20 mg, Lisinopril (blood pressure) 20 mg, and Norvasc (blood pressure) 10 mg, Once she had prepared the medication in 2 medicine cups Nurse #4 sat them on top of the medication cart. Nurse #4 locked the medication cart and left the 2 medicine cups of medication sitting on top and walked away into a nourishment room and shut the door. The medication cart was parked directly on the main hallway of the facility directly outside of a resident room and there were numerous staff and residents going by the medication cart. After</p>	F 761			

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F 761	Continued From page 120 a minute Nurse #4 returned to the medication cart carrying a cup of thickened liquids. Nurse #4 picked up the 2 medicine cups of medications and the cup of thickened liquids and went to administer the medications. An interview was conducted with Nurse #4 on 06/23/21 at 9:39 AM. Nurse #4 stated that she left the 2 cups of medicine on top of the cart unsecured because she was nervous as this was her first day in the facility. She stated she always locked her cart and was so careful, but she was just very nervous. An interview was conducted with the Director of Nursing (DON) on 06/24/21 at 4:36 PM. The DON stated she expected Nurse #4 and all the nurses to keep all medication secure and locked up in the medication cart especially if walking away from the medication cart and it was out of sight.	F 761			
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observations, test tray, record review and resident and staff interviews the facility failed to provide palatable food that was appetizing in appearance, taste, and temperature for 6 of 6	F 804	#1 Re-education of Culinary Services Manager (CSM) on Next Level policies & Procedures regarding Nutritive Value, Appearance & Palatability by Regional	7/26/21	

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F 804	<p>Continued From page 121</p> <p>residents reviewed with food concerns (Resident #09, Resident #10, Resident #15, Resident #20, Resident #24, and Resident #40).</p> <p>The findings included:</p> <p>1 a. Resident #9 was readmitted to the facility on 03/10/21 with diagnoses that included anemia, hypertension, diabetes, and depression.</p> <p>The quarterly Minimum Data Set (MDS) dated 03/22/21 indicated that Resident #9 was cognitively intact for daily decision making and required set up assistance with eating.</p> <p>An observation and interview were conducted with Resident #9 on 06/25/21 at 12:43 PM. Resident #9 stated that the dietary department had served him a baked potato with no butter and he asked the staff to bring him some butter and by the time the staff brought the butter the baked potato was cold and would not melt the butter. Resident #9 stated that the mixed vegetables had no seasoning on them and were bland and added that they continued to send him tea despite telling them numerous time he did not drink tea. Resident #9's lunch tray remained sitting on his bedside table with only a few bites gone from the meal along with cup of tea.</p> <p>1 b. Resident #10 was admitted to the facility on 08/15/10 with diagnoses that included anemia, hypertension, peripheral vascular disease, and hyperlipidemia.</p> <p>The quarterly Minimum Data Set (MDS) dated 03/26/21 indicated that Resident #10 was cognitively intact for daily decision making and required set up assistance for eating.</p>	F 804	<p>Clinical Services Director on 7/15/21.</p> <p>#2 Re-education of Culinary Staff on Next Level policies & Procedures regarding Nutritive Value, Appearance & Palatability on 7/15/21 by Regional Clinical Services Director</p> <p>#3 Food Committee to occur Bi-Monthly, Hosted by CSM , minutes to be recorded on Food Committee form and shared with QAPI team. Resident Council will vote on A la Carte Menu and Meal of the Month in Ad Hoc meeting on 7/22/21.</p> <p>#4 Culinary Department will complete an initial Resident satisfaction audit of alert & oriented residents (evidenced by BIMS)related to the quality of resident dining experience and use feedback to correct any issues in the kitchen, by no later than 7/26/21. CSM will report findings to the QAPI committee for review and recommendation. All results will be discussed during food committee meetings. Test Tray Audits to be completed five (5) times weekly x 12 weeks by CSM to check accuracy, condiments and proper temperature. This will occur in the repeating order of Breakfast on Monday & Thursday, Lunch on Tuesday & Friday, Dinner on Wednesdays. All results will be reported & discussed in IDT stand up & stand down as deemed appropriate. Findings will be reported to the QAPI committee for review and recommendation. The administrator will present results of the audits to the quality assurance committee x 3 months. The QAPI committee may modify this plan to ensure the facility remains in compliance.</p>		

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F 804	<p>Continued From page 122</p> <p>An observation and interview were conducted with Resident #10 on 06/25/21 at 12:57 PM. Resident #10 stated that on a scale of 1 to 10 he would give lunch a 3. He stated that he was served a fish square with no tarter sauce and a baked potato with no butter and he asked the staff to bring him tarter sauce and butter and by the time they got back with the tartar sauce and butter his food was stone cold. Resident #10's lunch tray remained sitting on his bedside table and was untouched.</p> <p>1 c. Resident #15 was readmitted to the facility on 10/17/20 with diagnoses that included asthma, diabetes, vitamin D deficiency, gout, and others.</p> <p>The comprehensive Minimum Data Set (MDS) dated 04/09/21 indicated that Resident #15 was cognitively intact for daily decision making and required set up assistance with eating.</p> <p>An observation and interview were conducted with Resident #15 on 06/25/21 at 1:01 PM. Resident #15 was resting in bed and was eating some meat that her family had brought into the facility. The lunch tray that was served to Resident #15 was sitting beside her bed. Resident #15 stated that when her meal tray arrived from the kitchen it was not hot and they had sent the fish with no tartar sauce and no butter for her baked potato and by the time the tarter sauce and butter arrived the food was too cold to eat. She stated that the mixed vegetables were mushy and bland, and the fish square was just too cold to eat.</p> <p>1 d. Resident #20 was admitted to the facility on 04/08/21 with diagnoses that included chronic obstructive pulmonary disease, severe protein</p>	F 804			

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F 804	<p>Continued From page 123 calorie malnutrition, and anemia.</p> <p>The comprehensive Minimum Data Set (MDS) dated 04/15/21 for Resident #20 indicated that he was cognitively intact for daily decision making and required one-person assistance with eating.</p> <p>An observation and interview were conducted with Resident #20 on 06/25/21 at 1:55 PM. Resident #20's lunch tray sat on his bedside table and was noted to have only a few bites missing from it. Resident #20 stated that he did not eat fish and the mixed vegetables were mushy and he could not eat it.</p> <p>1 e. Resident #24 was admitted to the facility on 05/02/19 with diagnoses that included end stage renal disease, chronic obstructive pulmonary disease, heart failure and others.</p> <p>The quarterly Minimum Data Set (MDS) dated 06/13/21 indicated that Resident #24 was cognitively intact for daily decision making and required set up assistance with eating.</p> <p>An observation and interview were conducted with Resident #24 on 06/25/21 at 1:10 PM. Resident #24 was sitting in her wheelchair with her meal tray in front of her. She stated that when she received the meal tray the fish square was cold and mushy not crunchy at all and the mixed vegetables were bland with no seasoning. She stated she had requested a sandwich of some kind but had not yet gotten it.</p> <p>1 f. Resident #40 was admitted on 05/01/20 with diagnoses that included stroke, diabetes, anemia, and hypertension.</p>	F 804			

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F 804	<p>Continued From page 124</p> <p>The comprehensive Minimum Data Set (MDS) dated 05/09/21 for Resident #40 indicate that she was cognitively intact for daily decision making and required one-person assistance with eating.</p> <p>Review of Resident #40 meal tray ticket on 06/25/21 revealed that her dislikes were grits.</p> <p>An observation and interview were conducted with Resident #40 on 06/25/21 at 8:51 AM. Resident #40 stated that she had told the staff numerous times that she did not eat grits and she was observed to have a bowl of grits on her tray. The grits were congealed and could be picked up as one blob of grits with the spoon. Resident #40 also received a piece of burnt black toast and stated her eggs were colder than room temperature and she could not eat that cold food.</p> <p>An interview was conducted with Cook #2 on 06/25/21 at 10:39 AM. Cook #2 stated he had been cooking on and off for 9 months and usually cooked at breakfast and lunch. Cook #2 stated that this morning for breakfast he served grits, eggs, bacon or sausage and toast. He explained that the Dietary Aides (DA) would call out the likes and dislikes off the tray ticket and he would plate the meal based off the tray ticket. Cook #2 stated that another DA would place the drink and condiments on the tray and give it one final review to ensure it was accurate before sending it out to the residents. Cook #2 further explained that he checked the temperature of the food before it got plated so he knew that it was hot when it left the kitchen and stated that the food sat for long periods of time on the hallway and that was one reason why the food was cold when the residents received it. He added that he used a lot of Styrofoam containers to serve food in</p>	F 804			

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F 804	<p>Continued From page 125</p> <p>because he did not like the food to run together and acknowledged that the food did not stay as hot in styrofoam containers as it did on a hot plate with a lid.</p> <p>An interview was conducted with DA #1 on 06/25/21 at 10:44 AM. DA #1 confirmed that he worked the tray line and was usually the one calling out the likes and dislikes from the residents meal tickets and then doing the final check of the tray before it went out the floor to be served to the residents. DA #1 stated that he must have overlooked Resident #40's dislikes of grits and the burnt toast when he was doing the final check of her tray earlier on the shift.</p> <p>2. An observation of the lunch tray line was conducted on 06/25/21 at 12:01 PM. A test tray was requested at this time as well. The menu included a fish square, half of a baked potato, and mixed vegetables. Temperature monitoring was conducted with Cook #2 on 06/25/21 at 12:05 PM and revealed the following:</p> <ul style="list-style-type: none"> -Fish Square: 186-degree Fahrenheit (F) and when sampled it was 120-degree F. -Half of baked potato: 180-degree F and when sampled it was 120-degree F. -Mixed vegetables: 190 degrees F and when sampled it was 139-degree F. <p>The test tray was plated at 12:15 PM and sampled at 12:30 PM with Cook #3.</p> <p>When the tray lid was removed from the tray there was no visible steam coming from the tray. The tray was served with no butter for the baked potato. Cook #3 stated that the fish was chewy and room temperature at best and the mixed</p>	F 804			

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F 804	Continued From page 126 vegetables were bland but tasted "terrible" she added that the mixed vegetables were the warmest item on the tray but were also the worse. Cook #3 stated that she preferred to have butter with her baked potato, and none was served with the test tray or with the resident's tray. The Dietary manager was unavailable for interview on 06/25/21 at 1:00 PM. An interview with the Administrator was conducted on 06/25/21 at 3:34 PM. The Administrator stated that he had received numerous grievances from residents about the food and indicated that they were "quite legit." He stated that two weeks ago he met with the dietary department to go over all the concerns including food temperature. The Administrator stated that they began paging overheard to alert the direct care staff that the meals trays were on the unit and ready to be served. The Administrator stated that in the 8 weeks that he had been at the facility he had attempted to tackle the dietary concerns by simplifying the processes one by one. He continued to explain that on July 6, 2021 there was a new company taking over the dietary department and he was hopeful that would help with the number of food complaints. The Administrator added he expected the resident to receive a hot meal that appeared appetizing in appearance, taste, and temperature.	F 804			
F 806 SS=E	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident	F 806		7/26/21	

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F 806	<p>Continued From page 127</p> <p>allergies, intolerances, and preferences;</p> <p>§483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice;</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, resident and staff interviews the facility failed to obtain and honor food preferences for meals for 5 of 6 residents reviewed with food complaints (Resident #15, Resident #20, Resident #24, Resident #40, and Resident #10) and failed to offer and have available substitutions when residents refused food items (Resident #10).</p> <p>The findings included:</p> <p>1 a. Resident #15 was readmitted to the facility on 10/17/20 with diagnoses that included asthma, diabetes, vitamin D deficiency, gout, and others.</p> <p>The comprehensive Minimum Data Set (MDS) dated 04/09/21 indicated that Resident #15 was cognitively intact for daily decision making and required set up assistance with eating.</p> <p>An interview was conducted with Resident #15 on 06/24/21 at 10:45 AM. Resident #15 stated that the facility used to come around and ask what she wanted for lunch and supper and we would have the ability to choose what we wanted to eat. She stated that they were no longer doing that and so she was served whatever was on the menu and there was no alternate menu provided but the facility had an always available menu but when you requested something off of it we were told it was unavailable. Resident #15 explained</p>	F 806	<p>#1 Select Choice Menu for residents will be offered through new menu management software SNO commencing on implementation.</p> <p>#2 Re-education of Culinary Services Manager (CSM) on Next Level policies & Procedures regarding Resident allergies, honoring preferences and substitutions via the always available menu.</p> <p>#3 Re-education of Culinary Staff on Next Level policies & Procedures regarding Resident allergies, honoring preferences and substitutions via the always available menu. Resident preferences were audited for interviewable residents to ensure preferences are updated and accurate and be uploaded in the new menu management software New Always available menu has been posted and adhered to as of 14 July 2021 with new and updated options. Department Heads round five (5) days per week to ensure resident received per their preference Manager on Duty will round Saturdays and Sundays ensure resident and preferences honored. Monitoring will be completed two (2) times weekly for four (4) weeks, then weekly for eight (8) weeks and as necessary thereafter.</p> <p>#4 Food Committee to occur Bi-Monthly,</p>		

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F 806	<p>Continued From page 128</p> <p>that the last 3 nights they dietary department had served her a salad without asking if that was what she wanted. Resident #15 stated "they took the right to choose what I want to eat away from me."</p> <p>1 b. Resident #20 was admitted to the facility on 04/08/21 with diagnoses that included chronic obstructive pulmonary disease, severe protein calorie malnutrition, and anemia.</p> <p>The comprehensive Minimum Data Set (MDS) dated 04/15/21 for Resident #20 indicated that he was cognitively intact for daily decision making and required one-person assistance with eating.</p> <p>A review of Resident #20's tray ticket on 06/23/21 revealed Resident #20 was on a regular diet. No likes or dislikes were noted on the tray ticket.</p> <p>An observation and interview were conducted with Resident #20 on 06/25/21 at 1:55 PM. Resident #20's lunch tray sat on his bedside table and was noted to have only a few bites missing from it. Resident #20 stated that he did not eat fish and added that they used to let us choose what we wanted for meals, but they stopped doing that a few weeks ago. Resident #20 stated that he liked choosing what he wanted for his meals and wished they would start doing that again.</p> <p>A1c. Resident #24 was admitted to the facility on 05/02/19 with diagnoses that included end stage renal disease, chronic obstructive pulmonary disease, heart failure and others.</p> <p>The quarterly Minimum Data Set (MDS) dated 06/13/21 indicated that Resident #24 was cognitively intact for daily decision making and</p>	F 806	<p>to include resident decision on always available menu options - Hosted by CSM , minutes to be recorded on Food Committee form and shared with QAPI team. The Administrator will report findings of the monitoring to the Interdisciplinary Team (IDT) during QAPI meetings monthly for three (3) months and will make changes to the plan as necessary to maintain compliance with resident ROM/mobility.</p>		

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F 806	<p>Continued From page 129 required set up assistance with eating.</p> <p>An observation and interview were conducted with Resident #24 on 06/25/21 at 1:10 PM. Resident #24 stated that the facility continued to send her oatmeal despite telling them numerous times that she did not eat oatmeal. She added that the staff used to come around and take my order for lunch and supper and I could choose between the main menu and an alternate menu, but they stopped doing that a few weeks ago. Now they serve me the main course and if I don't like it, I will usually order some food and have it delivered.</p> <p>1qd. Resident #40 was admitted on 05/01/20 with diagnoses that included stroke, diabetes, anemia, and hypertension.</p> <p>The comprehensive Minimum Data Set (MDS) dated 05/09/21 for Resident #40 indicate that she was cognitively intact for daily decision making and required one-person assistance with eating.</p> <p>Review of Resident #40 meal tray ticket on 06/25/21 revealed that her dislikes were grits.</p> <p>An observation and interview were conducted with Resident #40 on 06/25/21 at 8:51 AM. Resident #40 stated that she had told the staff numerous times that she did not eat grits and she was observed to have a bowl of grits on her tray. She added that they used to come around and ask me what I wanted for my meals, but they have stopped doing that here lately, so I just get whatever is on the menu.</p> <p>An interview was conducted with Cook #1 on 06/23/21 at 12:15 PM. Cook #1 stated that the</p>	F 806			

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F 806	<p>Continued From page 130</p> <p>facility menus were selected by the Dietary Manager (DM) a month at a time. Cook #1 stated that the used to go around and obtain the residents preference of what they wanted to eat for lunch and supper but they have not done that in several weeks but could not say why they stopped doing that. He stated that each resident got what was on the menu unless they communicated to the nursing staff that they wanted something else. Cook #1 also stated that he thought the Dietitian came around when the resident admitted and asked them their likes and dislikes but he was not certain.</p> <p>An interview was conducted with Cook #2 on 06/25/21 at 10:39 AM. Cook #2 stated that he had been cooking at the facility on and off for 9 months. He stated that they used to go around and talk to the resident and find out what their preference of meal was for lunch and supper, but they stopped doing that a few weeks ago and he could not say why. Cook #2 stated that everyone was served the main dish at the facility because the facility did not have an alternate menu but did offer a few times on an always available menu.</p> <p>An interview was conducted with Dietary Aide (DA) #1 on 06/25/21 at 10:44 AM. DA #1 stated that he had worked at the facility for a few months and when he first came he used to go around an ask what each resident wanted for lunch and supper but we stopped doing that because they did not have enough staff to do that so the resident got what was on the menu unless they communicated to the nursing staff they wanted something else.</p> <p>The Dietary Manager was unavailable for interview on 06/25/21 at 1:00 PM.</p>	F 806			

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F 806	<p>Continued From page 131</p> <p>An interview with the Administrator was conducted on 06/25/21 at 3:34 PM. The Administrator stated that he had received numerous grievances from residents about the food and indicated that they were valid. The Administrator stated that in the 8 weeks that he had been at the facility he had attempted to tackle the dietary concerns by simplifying the processes one by one. He continued to explain that on July 6, 2021 there was a new company taking over the dietary department and he was hopeful that would help with the number of food complaints. The Administrator added he expected the resident to be able to choose what they wanted to eat for their meals, and have it served to them as they preferred.</p> <p>2. Resident #10 was admitted to the facility on 08/15/10 with diagnoses that included diabetes mellitus and traumatic spinal cord injury.</p> <p>The quarterly Minimum Data Set (MDS) assessment dated 03/26/21 revealed Resident #10 was cognitively intact and had no behavior symptoms. The MDS indicated the Resident required supervision with set up assistance with eating.</p> <p>A review of Resident #10's care plan revised on 07/10/20 revealed the Resident was at risk for weight changes related to diabetes mellitus with the goal that Resident #10 would maintain adequate nutritional status as evidence by maintaining his weight and consuming 75% of his</p>	F 806			

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F 806	<p>Continued From page 132</p> <p>meals. The interventions included serving a regular diet as ordered and obtaining the Residents likes and dislikes.</p> <p>During an interview with Resident #10 on 06/21/21 at 12:42 PM the Resident stated that he did not like the fact that he was not allowed to choose his meal preference. He explained that the facility offered alternate menus for each meal but he was not able to choose which menu he preferred before they delivered his meal. Resident #10 continued to explain that he had lived in the facility for "a lot of years" and he did not believe that it was asking too much to be able to receive the meal of his choice.</p> <p>An interview was conducted with Nurse Aide (NA) #9 on 06/23/21 at 10:25 AM. The NA explained that Resident #10 was alert and oriented and able to voice his wants and needs. The NA stated Resident #10 never complained of anything except not being able to get the meal of his choice. The NA stated that Resident #10 stated to her yesterday (06/22/21) that he did not like the meal they served him for lunch and she offered to get him an alternate tray but he was mad at that point and explained that when we go to a restaurant we can choose what meal we wanted off the menu and he did not think it was asking too much to be able to choose which meal he wanted off the menu here at the facility.</p> <p>During an interview with Nurse Aide (NA) #8 on 06/23/21 at 5:47 the NA explained that Resident #10 did not like the supper that was given to him last evening (06/22/21) and I offered to get him something from the "Always Available" menu. She stated that when she asked Cook #1 for a cheeseburger for Resident #10 the Cook told her</p>	F 806			

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F 806	<p>Continued From page 133</p> <p>that the cheeseburger was not available and gave her a cold peanut butter and jelly sandwich for Resident #10. The NA stated she gave the sandwich to the Resident but he did not eat the sandwich because it was too hard and cold.</p> <p>An interview with Resident #10 on 06/23/21 at 6:23 revealed on last evening's supper tray he was given a meal that had a ground up meat (he is not on ground meat) that he could not identify. The Resident stated NA #9 offered to get him a cheeseburger from the Always Available menu but was given a peanut butter and jelly sandwich instead. Resident #10 explained that the sandwich was so hard and cold that he could not eat it. The Resident stated he did not think that would have happened if he had been able to choose his meal prior to serving time.</p> <p>During an interview with Cook #1 on 06/23/21 at 6:39 PM he explained that Resident #10 was on a regular diet with double portions for his supper meal. The Cook stated the Resident was not on a mechanically altered diet but that Resident #10 received boneless ribs that were so soft they had fallen apart for last evening's supper. The Cook confirmed the residents were not allowed to choose between the main meal and an alternate meal but stated they had an Always Available menu that they could choose from if they wanted to. When the Cook was asked about Resident #10 not being given the cheeseburger he wanted last evening the Cook said they were all out of cheeseburgers.</p> <p>On 06/25/21 at 10:10 AM during an interview with the Director of Nursing (DON) she stated that it was not unreasonable for the residents to be allowed to choose their meals from the planned</p>	F 806			

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F 806	Continued From page 134 menus and that if the Always Available menu indicated a food was always available then she expected the food to be available for the resident. During an interview with the Administrator on 06/25/21 at 2:46 PM the Administrator explained that it was reasonable for the residents to be able to choose the menu of their choice within reason and that there were plans in works for changes in the dietary department which should allow the residents to choose their meals.	F 806			
F 808 SS=D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff and resident interviews, the facility failed to provide the diet prescribed by the physician when a resident with a mechanical soft diet ordered received a puree dietary tray for 1 of 5 residents reviewed for dietary orders (Resident #5). Findings included: Resident #5 was re-admitted to the facility on 01/30/21 with diagnoses that included dementia with behavioral disturbances, diabetes, seizures, cerebral infarction, and protein-calorie	F 808	#1 Resident #5 diet order was updated on 6/24/21. Re-education of Culinary Services Manager (CSM) on Next Level policies & Procedures regarding Therapeutic & modified diets on 7/15/21 by Regional Culinary Manager. #2 Re-education of Culinary Staff on Next Level policies & Procedures regarding Therapeutic & modified diets on 7/15/21 by Regional Culinary Manager. #3 An audit of clinical charting system (PCC) and menu management system	7/26/21	

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F 808	<p>Continued From page 135 malnutrition.</p> <p>A physician's order dated 08/18/20 indicated Resident #5 was to receive a Mechanical Soft Diet with Puree meats. No new dietary orders were obtained since re-admission on 01/30/21.</p> <p>An observation on 06/23/21 at 5:45 PM revealed Resident #5 received a supper meal tray of full puree diet and contained applesauce as the dessert. Resident #5 was observed to have consumed the entire tray. Resident's meal ticket indicated a puree diet was ordered; however, under the preferences section the ticket listed add sandwich.</p> <p>An interview on 06/24/21 at 2:00 PM with the Director of Nursing (DON) revealed she expected Resident #5 to be served the diet ordered by the physician. The DON explained to her knowledge a sandwich would not be an allowable item on a puree diet. She acknowledged Resident #5's current diet order listed a mechanical soft diet with puree meats and was unsure why Resident #5 was served a puree diet for supper on 06/23/21.</p> <p>An observation and interview on 06/24/21 at 3:34 PM with Cook #1 revealed he had a stack of resident tray cards for the supper meal. Resident #5's meal ticket indicated he was to receive a Puree Diet and under the preference section the ticket further indicated to add a sandwich. Cook #1 verified Resident #5 was to receive a puree diet and when asked about the preferences section which contained the words "add a sandwich." Cook #1 stated sometimes residents get approved to have food items that are not typically listed under the traditional diet and it is</p>	F 808	<p>(SNO) to cross reference and ensure accuracy of diet orders will occur two times weekly, completed by the culinary service manager. Any findings out of compliance will be recorded on the SNO audit form. Newly hired direct and indirect care staff will receive education during orientation.</p> <p>#4 The Administrator will report findings of the monitoring to the Interdisciplinary Team (IDT) during QAPI meetings monthly for three (3) months and will make changes to the plan as necessary to maintain compliance.</p>		

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F 808	Continued From page 136 added to the tray card by the Dietary Manager. He elaborated to say he just plated whatever the ticket said and never questioned it. An interview on 06/24/21 at 3:46 PM with NA #3 revealed she had been assigned to care for Resident #5 on the evening shift (3-11 PM) on 06/23/21. NA #3 indicated she had assisted him with his evening meal of puree consistency. She explained he had eaten all of his meal which consisted of the following items: ham, mashed potatoes, mixed vegetables, and applesauce all of which NA #3 stated were puree consistency. NA #3 stated Resident #5 had received a puree diet for the last few years. Three attempts were made to contact the Dietary Manager; however, he was unavailable for interview during the survey. An interview on 06/25/21 at 2:46 PM with the Administrator revealed he expected all residents to be served the diets prescribed by the physician and was unsure why Resident was provided a puree diet on 06/23/21 or why Resident #5's tray card was not changed to a mechanical soft diet with puree meats when the order was changed.	F 808			
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	F 809		7/26/21	

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F 809	<p>Continued From page 137</p> <p>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.</p> <p>§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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, resident and staff interviews, the facility failed to provide snacks when requested for 1 of 1 resident (Resident #30) reviewed for snacks.</p> <p>The findings included:</p> <p>Resident #30 was admitted to the facility on 04/07/21 with diagnoses that included COPD, respiratory failure, and dementia.</p> <p>A Significant Change Minimum Data Set (MDS) dated 04/29/21 revealed he was mildly cognitively impaired but able to make his needs known.</p> <p>An interview on 06/21/21 at 11:44 AM with Resident # 30 revealed he had asked for snacks to be provided to him at bedtime, but indicated staff told him they are not available.</p> <p>An observation on 06/22/21 at 1:15 PM of the 500/700 hall nourishment revealed there were no snacks in the cabinets and the refrigerator contained 2 cartons of milk and 1 bowl of applesauce. No other food items were observed.</p>	F 809	<p>#1 Re-education of Culinary Services Manager (CSM) on Next Level policies & Procedures regarding appropriate provision of snacks and snack par levels. HS snacks made available to Resident #30.</p> <p>#2 Re-education of Culinary Staff on Next Level policies & Procedures regarding appropriate provision of snacks and snack par levels. Residents should have HS snacks made available to them between meals.</p> <p>#3 New par list has been posted for nourishment room replenishment. HS Snacks are standardized and distributed on trays to nursing staff for residents; sign off sheet now in place to record transaction. Nourishment rooms will be audited to ensure HS snacks are available . Monitoring will be completed two (2) times weekly for four (4) weeks, then weekly for eight (8) weeks and as necessary thereafter by Administrator.</p>		

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F 809	Continued From page 138 An interview on 06/23/21 at 5:47 PM with Nurse Aide (NA) #3 revealed she worked with Resident #30 on evening shift occasionally and he asked staff for snacks, but we do not always get snacks provided by the kitchen to give the residents so we have to tell them we don't have any. The kitchen doesn't keep extra snacks in there for us to give all the residents. An interview on 06/24/21 at 1:41 PM with Nurse Aide # 5 revealed Resident #30 was independent for eating, but often asked for snacks throughout the day including at bedtime, but snacks were typically not available after the kitchen closed in the evening. There was a code to the kitchen door and hall staff had not been provided with the access code. An interview on 06/25/21 at 8:41 AM with Resident #30 revealed he went to the nurses' station to look for a snack but could not locate any. He indicated he did not ask staff last night for a snack because as of recent when he asked for a bedtime snack, he had been told they were not available. Resident #30 stated lost money in the snack machine trying to get some cheese crackers, because he wanted a snack around 11 PM to hold him over until breakfast. An interview on 06/25/21 at 9:44 AM with the Director of Nursing revealed she expected snacks to be offered at bedtime and available for all residents who request at all times. An interview on 06/25/21 at 2:46 PM with the Administrator revealed he knew snacks had previously been a concern but thought the issue had resolved. He expected snacks to be available	F 809	#4 Food Committee to occur Bi-Monthly, to include resident decision on HS Snack and nourishment room stocking options - Hosted by CSM , minutes to be recorded on Food Committee form and shared with QAPI team. The Administrator will report findings of the monitoring to the Interdisciplinary Team (IDT) during QAPI meetings monthly for three (3) months and will make changes to the plan as necessary to maintain compliance.		

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F 809	Continued From page 139 and provided to any resident who may want one.	F 809			
F 812 SS=E	<p>Attempts were made to contact the Dietary Manager who was unable to be reached during the survey.</p> <p>Food Procurement, Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)</p> <p>§483.60(i) Food safety requirements. The facility must -</p> <p>§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.</p> <p>§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 facility staff interviews, the facility failed to label and date opened food items in 1 of 1 reach-in refrigerators, 1 of 1 dry goods storage areas, and 2 of 2 nourishment room refrigerators, failed to remove a case of expired individual packets of sour cream from 1 of 1 walk-in refrigerators, and failed to store four, 10-pound packages of ground beef in a way that prevented cross contamination</p>	F 812	<p>#1 Unlabeled/Expired food items were discarded. Re-education of Culinary Services Manager (CSM) on Next Level Policies & Procedures for Sanitation & Storage on 7/15/21 by Regional Culinary Services Director.</p> <p>#2 Re-education of Culinary Staff on Next Level Policies & Procedures for</p>	7/26/21	

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F 812	<p>Continued From page 140</p> <p>when they were stored on a wire shelf directly above a cardboard box of melons in 1 of 1 walk in refrigerators.</p> <p>Findings included:</p> <p>1. During a kitchen walk through with the Dietary Manager on 06/22/21 at 9:13 AM an observation of a reach-in refrigerator revealed an opened, undated bag of shredded cheddar cheese and one plastic container of pimento cheese spread that was opened and undated.</p> <p>An observation of the walk-in refrigerator in the kitchen on 06/22/21 at 9:16 AM revealed a case of individually wrapped packets of sour cream with an expiration date of 06/21/21.</p> <p>An observation of the kitchen's dry storage area on 06/24/21 at 3:49 PM revealed an opened, partially used package of gravy mix that was opened and undated.</p> <p>An observation of the facility's walk-in refrigerator on 06/24/21 at 3:37 PM revealed four 10-pound packages of ground beef located on the second to bottom shelf directly over a cardboard box that contained fresh melons. The ground beef packages were not being stored on trays or anything that would prevent possible cross contamination from ground beef juices dripping on the melons below.</p> <p>A review of the facility's policy titled "Food Storage" dated 10/2019 revealed "the Dining Services Director / Cook(s) ensures that all food items are stored properly in covered containers, labeled and dated and managed in a manner to prevent cross contamination.</p>	F 812	<p>Sanitation & Storage on 7/15/21 by Regional Culinary Services Director.</p> <p>#3 Sanitation audits will be completed with a Next Level regional and the facility administrator one (1) time a week x 12 weeks on weekly sanitation audit form. Findings will be reported to the QAPI committee for review and recommendation. The administrator will present results of the audits to the quality assurance committee x 3 months. The QAPI committee may modify this plan to ensure the facility remains in compliance * (CMS mock survey tool will be used on next level app as seen below and monitored for increase/decrease in score)</p> <p>#4 The CSM will complete the manager checklist twice daily five (5) times a week x 12 weeks to ensure proper food storage and sanitation practices and report findings to the QAPI committee for review and recommendation. The administrator will present results of the audits to the quality assurance committee x 3 months. The QAPI committee may modify this plan to ensure the facility remains in compliance.</p>		

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F 812	Continued From page 141 During an interview with the Dietary Manager on 06/22/21 at 9:18 AM, he reported it was the responsibility of the cooks and himself to ensure that all food items were labeled and dated when opened. He reported he had not been in the facility for a few days as he had been on vacation and stated it was not an excuse as his staff were aware of his expectation of ensuring that food items were labeled and dated. During an interview with Cook #3 on 06/24/21 at 3:51 PM, she reported the Dietary Manager had not been in the facility since 06/22/21 and that opened food items should be dated. She reported the opened and undated sandwich bread was probably used by the cook who was working the early shift and did not date the bread after use. She also reported ground beef should not be stored above other food and that they had received a delivery of food items on the earlier shift and the staff at the time did not store the ground beef appropriately. She reported she would move the ground beef away from the melons and store it on the bottom shelf of the refrigerator. During an interview with the Administrator on 06/25/21 at 2:45 PM, he stated dietary staff were responsible for ensuring that all opened food items were properly labeled and stored and it was his expectation that food items were labeled and dated and food items were stored in accordance with the facility's policy.	F 812			

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F 812	Continued From page 142 2. An observation on 06/22/21 at 12:56 PM of the nourishment room across located on the 400 hall revealed: Inside the refrigerator the following items were located: - A 32 ounce (oz) full size bottle of flavored coffee creamers which was not labeled with a name or an opened date. - A half consumed 20 oz bottle of soda which was not labeled with a name or an opened date. - A full 12 oz bottle of Fruit Punch flavored electrolyte drink was not labeled with a name or date. - A partially consumed 22 oz bottle of strawberry syrup with a broken lid which was not labeled with a name or open date. - An unopened 16 oz bottle of balsamic vinaigrette dressing not labeled with a name or date. - Two 7.25 oz partially consumed bottles of ice cream topping. One chocolate flavor and the other chocolate fudge flavor. Neither bottle contained a label with a name or date opened. - One 46 oz opened, and partially consumed paper carton of thickened sweet tea with lemon flavor labeled 6/3. Inside the freezer the following items were located: - 2 one-gallon unopened plastic containers of chocolate flavored ice cream not labeled with a name. - 2 one-gallon plastic containers of vanilla flavored ice cream; one unopened without a name and one partially consumed without a name or open/discard date.	F 812			

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F 812	Continued From page 143 - A partially consumed one-gallon container of neapolitan flavored ice cream without a name or open/discard date. - 4 16.9 oz partially consumed bottles of frozen purified water without a name or open/discard date. - 2 frozen microwavable dinners without a name. An interview on 06/25/21 at 9:44 AM with the Director of Nursing revealed she expected all food items to be stored properly and the nourishment rooms to be cleaned daily by dietary and/or housekeeping and all open, unlabeled and/or expired items to be discarded daily and the nourishment room was to be used for resident food items only. An interview on 06/25/21 at 2:46 PM with the Administrator revealed he expected the nourishment rooms to be checked daily and all food items to be stored properly and checked by dietary and/or housekeeping daily to discard items.	F 812			
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted	F 842		7/26/21	

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F 842	<p>Continued From page 144</p> <p>professional standards and practices, the facility must maintain medical records on each resident that are-</p> <p>(i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized</p> <p>§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-</p> <p>(i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.</p> <p>§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.</p> <p>§483.70(i)(4) Medical records must be retained for-</p> <p>(i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law.</p>	F 842			

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F 842	<p>Continued From page 145</p> <p>§483.70(i)(5) The medical record must contain-</p> <ul style="list-style-type: none"> (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record reviews and staff interviews, the facility failed to maintain a complete and accurate medical record when a staff member altered a resident's answers provided on the Brief Interview of Mental Status (BIMS) assessment to reflect the resident was cognitively intact for 1 of 1 residents sampled (Resident #9).</p> <p>Findings include:</p> <p>Resident #9 was originally admitted to the facility on 10/16/19 and recently readmitted on 3/10/21 with diagnoses that included diabetes.</p> <p>The most recent quarterly Minimum Data Set dated 3/22/21 revealed Resident #9 to be cognitively intact with the ability to make his needs known and understand others.</p> <p>Resident #9's care plan did not reveal his cognitive status or ability to make his needs known.</p> <p>A BIMS assessment, a standardized testing</p>	F 842	<p>#1 On 6/22/2021 Social worker completed a Brief Interview of Mental Status (BIMS) assessment for accuracy BIMS score.</p> <p>#2 On 6/22/2021, Clinical Region MDS consultant provide 1 on 1 education on RAI manual section C.</p> <p>#3 On 6/26/2021 Social worker and MDS educate on RAI manual section C for BIMS. Social worker will complete the BIMS assessment.</p> <p>#4 DON/Designee will audit all current residents for accuracy of BIMS score three (3) times a week for two (2) weeks, twice a week for two (2) weeks, then weekly for eight (8) weeks and as necessary thereafter. The administrator will report finding of monitoring to the IDT during QAPI meetings monthly for three (3) months and will make changes to the plan as necessary.</p>		

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F 842	<p>Continued From page 146</p> <p>system comprised of structured questions to determine the cognition status on the MDS and remains a part of the permanent medical record, dated 6/22/21 revealed the assessment was opened and completed by Social Worker #1 on 6/22/21 with the question related to accuracy of the current year marked as "missed by greater than 5 years". The assessment reflected it was edited by MDS Nurse #1 on 6/22/21 for the question related to the accuracy of the current year changed to correct. The assessment was later locked on 6/22/21 at 1:56 PM.</p> <p>An interview on 6/22/21 at 2:22 PM with Social Worker #1 (SW) revealed she had been the facilities Director of Social Services since March 2021 and was expected to conduct a BIMS interview on each resident to correlate with the frequency of the MDS assessment. SW #1 indicated she completed a BIMS assessment to assess Resident #9's cognitive status on the morning of 6/22/21 which reflected Resident #9 was moderately impaired for cognitive status related to Resident #9 identifying the current year as "2001". SW #1 stated shortly after completing the assessment, MDS Nurse #1 approached SW #1 and asked her to alter her documentation to reflect Resident #9 to be cognitively intact. SW #1 explained she refused to alter the documentation of the assessment she conducted and inaccurately transcribe Resident #9's answers to reflect differently than the answers provided by Resident #9. She reported MDS Nurse #1 said she would reconduct the BIMS assessment herself. After the MDS Nurse #1 conducted the assessment, SW #1 reported MDS Nurse #1 reapproached her and indicated Resident #9 had also indicated to her the year was "2001" but after prompting, Resident #9 was able to identify the</p>	F 842			

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F 842	<p>Continued From page 147</p> <p>accurate year to be 2021. SW #1 elaborated that MDS Nurse #1 told her she would modify SW #1's documentation on the original assessment to reflect Resident #9 answered the year as being correct because she believed Resident #9 to be cognitively intact despite, he provided an incorrect answer.</p> <p>An interview on 6/22/21 at 2:56 PM with MDS Nurse #1 revealed SW #1 was responsible for ensuring BIMS assessments were completed and accurate in the medical record and she did not routinely have involvement in conducting the BIMS assessment for Resident #9 in the absence of SW #1 and further revealed the previous administrator had appointed the activity director to perform the BIMS assessment if SW #1 was unable to complete them. MDS Nurse #1 indicated after SW #1 documented Resident #9's change in cognition on the BIMS assessment conducted on 6/22/21 she asked SW #1 if she was aware of a change in cognition and reported SW #1 stated she was not sure, but Resident #1 had failed to accurately identify the correct year during the interview. MDS Nurse #1 explained Resident #9 was routinely cognitively intact and felt the BIMS should be repeated and stated she would conduct one herself. MDS Nurse #1 elaborated that when initially conducting the BIMS assessment herself, Resident #9 identified the current year to be "2001" and further elaborated she prompted Resident #9 what last year was and Resident #9 identified last year to be "2020" and she continued to ask Resident "If last year was 2020, what does it make this year" and she stated "is 2001 your final answer?" According to MDS Nurse #1, Resident #9 then stated "2021, you know I know what year it is; I just wasn't saying it right." MDS Nurse #1 further stated, she</p>	F 842			

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F 842	<p>Continued From page 148</p> <p>felt Resident #9 was cognitively intact and therefore modified SW #1's original documentation to reflect Resident #9 answered the current year accurately because he was able to state it after prompting. MDS Nurse #1 indicated she had not been trained to conduct the BIMS assessment to assess a resident's cognition and was not aware prompting Resident #9 was not allowed when asking the resident to identify the current year.</p> <p>An interview on 6/22/21 at 2:56 PM with the Regional MDS Nurse Consultant revealed she expected the BIMS assessment to be completed accurately and timely. The Regional MDS Nurse Consultant also indicated if MDS Nurse #1 questioned the accuracy of the original BIMS assessment completed on 6/22/21 by SW #1, MDS Nurse #1 should have opened an additional BIMS assessment and completed her own instead of modifying the one written by SW #1 and written a note to reflect the decision to repeat the assessment. The Regional MDS Nurse Consultant explained after the second BIMS assessment was completed by MDS Nurse #1 for validation and Resident #9 provided the answer to the question referencing the current year as "2001", MDS Nurse #1 should have documented that response as incorrect by greater than 5 years which would have reflected a lower BIMS assessment score. The Regional MDS Consultant stated she expected MDS Nurse #1 to follow the guidelines outlined in the Resident Assessment Instrument (RAI) manual which reads in part that prompts should not be provided when asking a resident the question, "What year is it?"</p> <p>An interview on 6/23/21 at 9:48 AM with the</p>	F 842			

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F 842	Continued From page 149 Administrator revealed he expected the BIMS assessment be completed accurately by a trained and qualified individual. He stated he was not aware MDS Nurse #1 had not been trained to complete a BIMS assessment. The Administrator explained when Resident #9 answered the question of the current year as "2001", MDS Nurse #1 should have documented the BIMS assessment to reflect that was answered incorrectly.	F 842			
F 880 SS=E	<p>Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)</p> <p>§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.</p> <p>§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:</p> <p>§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;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include,</p>	F 880		7/26/21	

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F 880	<p>Continued From page 150</p> <p>but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.</p>	F 880			

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F 880	<p>Continued From page 151</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, record reviews, and resident and staff interviews, the facility failed to ensure a COVID-19 positive unit was labeled and personal protective equipment was readily available to staff outside the unit for 1 of 1 COVID-19 positive quarantine units. The facility further failed to ensure staff donned PPE according to the Enhanced Droplet Precautions Isolation sign posted on the door for 1 of 4 residents who resided on the observation quarantine unit (Resident #40). The facility also failed ensure proper glove usage and hand hygiene were completed when a nurse was observed performing a pressure ulcer treatment for 1 of 1 resident reviewed for pressure ulcers (Resident #7). The facility failed to ensure a residents personal clothing was not laundered with a facility incontinence pad for 1 of 1 resident reviewed for laundry (Resident #17).</p> <p>Findings included:</p> <p>A review of a facility document titled Isolation-Categories of Transmission-Based Precautions revised 03/01/20 revealed standard precautions shall be used when caring for all residents regardless of their suspected or confirmed infectious status. Transmission-Based Precautions will be implemented for a resident who is documented or suspected to have a communicable disease or infection that can be transmitted to others. Resident confirmed positive for COVID-19 and persons under investigation (PUI) shall be placed on Enhanced Droplet Isolation Precautions in addition to standard precautions and signage placed that illustrated the use of a gown, face mask, eye wear and</p>	F 880	<p>#1 Post Enhanced Droplet Isolation Precaution signage outside the COVID-19 positive unit. Place PPE cart outside the COVID-19 positive unit and stock with N-95 masks, eye protection, gowns and gloves. NA#2 and Laundry Worker #1 on donning/doffing proper PPE according to Enhanced Droplet Isolation Precaution signage. Resident #17 personal laundry and incontinence pad relandered separately per policy. Education and updated skills competency for Nurse #8 on proper hand hygiene and glove usage during wound treatments.</p> <p>#2 Residents who reside in the facility have the potential to be affected.</p> <p>#3 Education to IP and Unit Managers on monitoring and maintaining appropriate Enhanced Droplet Isolation Precaution signage and readily available PPE supplies required to enter the COVID-19 positive unit. Current staff receive education on Transmission Based Precautions and complete skills competency on donning/doffing PPE upon hire. Newly hired staff to receive education on Transmission Based Precautions and complete skills competency on donning/doffing PPE upon hire. Education and updated skills competency for Nurse #8 on proper hand hygiene and glove usage during wound treatments completed by 7/26/21 by Director of Nursing. Education to licensed nurses and validation of current skills competency on proper hand hygiene and glove usage during wound treatments.</p>		

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F 880	Continued From page 152 gloves. A review of a document updated 11/20/20 and published by the CDC titled Preparing for COVID-19 in the Nursing Home indicated in part under section headed Evaluate and Manage Residents with symptoms of COVID-19, residents known or suspected of COVID-19 should be cared for by HCP's using all recommended PPE which includes use of a N-95 or higher level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a face shield that covered the front and sides of the face) gloves and a gown. The document defines HCP to include but not limited to, emergency medical service personnel, nurses, nursing assistants, physicians, technicians, therapist, phlebotomist, pharmacist, students and trainees, contractual staff not employed by the facility, and person not directly involved in patient care, but who could be exposed to infectious agents that can be transmitted in the healthcare setting (e.g., clerical, dietary, environmental services, laundry, security, engineering, and facilities management, administrative, billing, and volunteer personnel. 1. A continuous observation of the 700 hall on 06/21/21 began at 4:45 PM when the Administrator escorted the surveyor to the COVID-19 positive quarantine unit entrance through the main corridor of the 300 hall in the facility and ended at 5:30 PM when the surveyor exited the COVID-19 positive quarantine unit. There was no signage observed on the outside of the unit to indicate to staff and/or visitors that the unit was designated for COVID-19 positive patients and that PPE was required to enter the unit. There was one strand of crinkled yellow plastic taping that was hanging from the ceiling in	F 880	Conduct ongoing monthly Infection Prevention surveillance rounds to monitor for compliance with PPE. Laundry staff reeducated on the process of sorting, separating and properly laundering resident personal clothing and facility linens per The Linen Operation policy. Education to direct care staff on proper bagging of resident personal laundry separate from incontinence pads. Newly hired laundry staff and direct care staff will receive education upon hire. Infection Preventionist and Unit Manager to monitor signage posting and PPE use for quarantine unit, perform visual observations of 5 random staff for proper donning/doffing PPE, perform visual observations of 5 licensed nurses for proper hand hygiene and glove usage during wound care Infection Preventionist and/or Housekeeping Supervisor to perform visual observations of resident laundry and facility linen laundering process. Monitoring to be completed 5x/week for 4 weeks then, 3x/week for 8 weeks then, monthly for 3 months. #4 Administrator to report findings of quality assurance monitoring monthly for 6 months and make changes to the plan as necessary to maintain compliance with Infection Prevention practices		

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F 880	Continued From page 153 front of the unit which had wording that was unable to be read due to the tape being rolled into itself. There was one piece of white copy paper taped to the outside of the double doors which read: "Open door and place food on cart. Thanks." The surveyor immediately turned to the Administrator and verified these doors were the correct entrance to the COVID-19 positive unit and asked if PPE was required to enter the unit. The Administrator acknowledged that this was indeed the preferred entrance to the COVID-19 positive unit and stated, "Oh, do you need PPE? The PPE must be missing that was supposed to be located on a cart in the center blocking the entrance to the double doors. I am not sure where it must have been moved." The Administrator turned and left the surveyor in the hallway outside the double doors and traveled up the 300 hall to the Director of Nursing office door and notified her that PPE cart was not in place. The DON immediately exited her office and traveled along with the Administrator down to the 700 hall COVID-19 positive quarantine unit entrance and confirmed the PPE cart had been moved and she began looking on the 300 and 500 hall units for another cart available to be placed outside the unit. After approximately 10 minutes, a staff member walked down the 300 hall carrying a three door cart which included PPE of gown, goggles, and N-95 masks and handed the cart to the Administrator who sat it down in front of the double doors outside the unit. The surveyor donned a N-95 face mask, goggles, and a gown and again turned to the Administrator to request a pair of gloves which was a required PPE item to enter the COVID-19 positive unit. The Administrator grabbed a box of gloves from a nearby surface and offered the surveyor a pair from the box. When the surveyor asked the	F 880			

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F 880	<p>Continued From page 154</p> <p>Administrator about signage to identify the COVID-19 unit, he was unsure why there was not signage posted and said he would take care of it immediately. The surveyor then entered the COVID-19 positive unit for the observation on the 700 hall. The observation revealed 4 residents who were currently COVID-19 positive residing on the unit. Each resident resided in a single occupancy room; however, there was no signage outside of the rooms to indicate the resident was on Enhanced Droplet Precautions nor what PPE was required to enter the isolation room. There was however a PPE cart located outside each room which had extra gowns and N-95 masks. Nurse #3 was working the unit and she was observed to wear a gown, N-95 mask, eye protection, and gloves when she entered the room 702 to answer the call light. When Nurse #3 exited the room, she removed the gown and her gloves and discarded them in the trash and performed hand hygiene then don a clean gown and gloves before entering into room 705 when she rang her hand bell for assistance. At 5:30 PM, Nurse #3 escorted the surveyor down the hall towards the service hall entrance to exit the unit. When they approached the exit doors, the surveyor asked Nurse #3 where she was to discard her PPE upon exiting the unit. Nurse #3 said she was not sure where the biohazard box was located, but she retrieved a trash can from an unoccupied room nearby and collected the PPE from the surveyor when she exited. Nurse #3 reported she did not change nor clean/disinfect her eye protection between each resident.</p> <p>An interview on 06/21/21 at 5:30 PM with Nurse #3 revealed that was her first day to work on the COVID-19 positive unit. She indicated she did not</p>	F 880			

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F 880	<p>Continued From page 155</p> <p>see any PPE outside the unit which required she entered the unit to obtain PPE at the beginning of her shift but she did not question this since there was a cart located close to the door on the inside of the unit. Nurse #3 entered the unit through the service hall entrance and donned PPE inside the unit. She stated she did not enter the unit through the 700 hall double doors in the main corridor of the facility as surveyor was directed by the Administrator on that day. Nurse #3 explained she had been taught from her agency that she was required to wear a gown, gloves, N-95 mask, and eye protection when she entered the COVID-19 positive unit and that her gown and gloves must be discarded between residents. She elaborated and her eye protection was only cleaned/sanitized if it was visibly soiled, she left the unit, and at the end of her shift each day.</p> <p>An interview on 06/23/21 at 2:00 PM with the Director of Nursing (DON) revealed she was aware the 700 hall had been designated as the COVID-19 positive unit and currently had 4 residents who resided at present. She explained had been made aware there was no available PPE and signage located on the outside of the COVID-19 unit on the early evening of 06/21/21 by the Administrator. The DON stated the facility normally had a cart containing gowns, gloves, N-95 masks, and gloves which was placed in the center of the double doors to alert staff of the need for PPE before entering the unit and she was unsure why it was not in place on 06/21/21. She could not recall if signage had previously been posted to identify the unit as a COVID-19 positive unit but knew staff had been educated and were aware. The DON stated she expected staff to don full PPE to include a gown, gloves, eye protection, and gloves before entering the</p>	F 880			

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F 880	<p>Continued From page 156</p> <p>unit and to change their gloves and gown between each resident room. She revealed she expected the N-95 mask to be discarded at the end of the day or if the staff member left the unit and expected eye protection to be sanitized when it was visibly soiled or at least at the end of the shift. The DON indicated the newly positive cases were unvaccinated residents who had tested positive shortly after admission from the hospital and she believed they had not shown positive prior to admission.</p> <p>A follow up interview with the Administrator on 06/25/21 at 2:46 PM revealed he expected all staff to don full PPE before entering the COVID-19 positive unit and signage should be posted to alert staff and visitors that the unit was designated for COVID-19 positive patients. He further revealed he was not sure why the cart or signage was not in place on 06/21/21.</p> <p>2. A review of a facility document titled Isolation-Categories of Transmission-Based Precautions revised 03/01/20 revealed standard precautions shall be used when caring for all residents regardless of their suspected or confirmed infectious status. Transmission-Based Precautions will be implemented for a resident who is documented or suspected to have a communicable disease or infection that can be transmitted to others. Resident confirmed positive for COVID-19 and persons under investigation (PUI) shall be placed on Enhanced Droplet Isolation Precautions in addition to standard precautions and signage placed that illustrated the use of a gown, face mask, eye wear and gloves.</p> <p>A review of a document updated 11/20/20 and</p>	F 880			

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F 880	<p>Continued From page 157</p> <p>published by the CDC titled Preparing for COVID-19 in the Nursing Home indicated in part under section headed Evaluate and Manage Residents with symptoms of COVID-19, residents known or suspected of COVID-19 should be cared for by HCP's using all recommended PPE which includes use of a N-95 or higher level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a face shield that covered the front and sides of the face) gloves and a gown. The document defines HCP to include but not limited to, emergency medical service personnel, nurses, nursing assistants, physicians, technicians, therapist, phlebotomist, pharmacist, students and trainees, contractual staff not employed by the facility, and person not directly involved in patient care, but who could be exposed to infectious agents that can be transmitted in the healthcare setting (e.g., clerical, dietary, environmental services, laundry, security, engineering, and facilities management, administrative, billing, and volunteer personnel.</p> <p>An observation on 06/21/21 at 3:47 PM of the New Admission/ Quarantine (unvaccinated) unit revealed NA #2 and Laundry Worker #1 entered Resident #40's room who was on Enhanced Droplet Precautions. Both NA #2 and Laundry Worker #1 were not observed to don the full PPE to include a gown, gloves, N-95 mask, and eye protection listed on the posted signage on Resident #40's door. NA #2 and Laundry worker #1 were observed to wear a surgical mask when they both entered Resident #40's room to return a mesh bag of laundry. NA #2 placed the mesh bag on Resident #40's bed, turned off Resident #40's call light, and exited the room. Laundry Worker #1 and NA #2 were observed to use the hand sanitizer in the hallway to perform hand hygiene</p>	F 880			

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F 880	<p>Continued From page 158 after exiting the room.</p> <p>An interview on 06/21/21 at 3:50 PM with NA #2 and Laundry Worker #1 revealed they had entered Resident #40's room to return a mesh bag containing Resident's clothing which had been laundered. Each acknowledged they did not think about the signage posted before they entered the room of Resident #40 who resided on the Observation Quarantine Unit and admitted to only wearing a blue surgical mask as PPE when in the room. They both stated they forgot to don gloves but remembered to perform hand hygiene when they exited the room. They both indicated they had received education on COVID-19 precautions and knew all residents who the 400 hall were on Enhanced Droplet Precautions and full PPE should have been applied to enter the room.</p> <p>An interview on 06/23/21 at 2:00 PM with the Director of Nursing (DON) revealed she expected all staff to follow the Enhanced Droplet Precautions which required full PPE of a gown, N-95 mask, eye protection, and gloves to be worn each time a staff member entered the room of Resident #40. The DON further explained all staff had received training and were educated about transmission-based precautions and PPE application.</p> <p>An interview with the Administrator on 06/25/21 at 2:46 PM revealed he expected all staff to don full PPE before entering the rooms on the Observation Quarantine Unit where residents were on Enhanced Droplet Precautions.</p> <p>3. A facility document titled, "Infection Control Guidelines for All Nursing Procedures" revised</p>	F 880			

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F 880	<p>Continued From page 159</p> <p>August 2012 indicated in part: prior to having direct-care responsibilities for residents, staff must have appropriate in-service training on general infection control and exposure issues, including: facility protocols for isolation, location of all personal protective gear, location or medical waste disposal containers, facility exposure control plan, and facility protocol for occupational exposure to bloodborne pathogens. The document further indicated prior to having direct-care responsibilities for residents, staff must have appropriate in-service training on managing infections in residents, including: types of healthcare-associated infections, methods of preventing their spread, how to recognize and report signs and symptoms of infection, and prevention of the transmission of multi-drug resistant organisms. The document revealed Standard Precautions will be used in the care of all residents in all situations regardless of suspected or confirmed infectious disease. Standard Precautions apply to blood, body fluids, secretions, and excretions regardless of whether they contain visible blood, non-intact skin, and/or mucous membranes. Transmission-based precautions will be used whenever measures more stringent than standard precautions are needed to prevent the spread of infections. Employees must wash their hands for 10 to 15 seconds using soap and water or use alcohol-based hand rubs under the following conditions: before and after direct contact with residents, after removing gloves, and after contact with objects (e.g. medical equipment) in the immediate vicinity of the resident.</p> <p>An observation on 06/24/21 at 3:20 PM revealed Resident #7 lying in bed. From the treatment cart outside Resident #7's room, Nurse #8 sat</p>	F 880			

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F 880	<p>Continued From page 160</p> <p>supplies on an overbed table and applied three layers of clear plastic gloves on each hand and entered the room pushing the bedside table to the bed. Nurse #8 pulled back the sheet that was partially draped over Resident #7's small frame and realized Resident #7 needed incontinence care when her blue brief was heavily soiled. Nurse #8 turned on the call light for assistance and she doffs the top layered pair of gloves and leaves the bedside to locate brief in the resident's closet. She was unable to locate one, so she exited the room and returned with a white brief. Nurse #8 returned to Resident #7's bedside and began using disposable wipes to perform incontinence care and laying them in the inside of the brief. Nurse #8 then removed the brief from the bed and tossed it in the direction of the trash can, but the brief missed the trash can and made a thump noise in the floor. Nurse #8 turned to remove her second layer of gloves and began performing pressure ulcer care and removed a dressing. She applied a barrier cream to the entire buttocks and sacrum, then applied a clean brief, then covered Resident #7 with her sheet and wrapped her final layer of soiled gloves and the old pressure ulcer treatment together and tossing them in to the trash can. She then walked out of the room. Nurse #8 was not observed to perform hand hygiene during the entire observation or don/doff single use gloves appropriately.</p> <p>An interview on 06/24/21 at 3:38 PM with Nurse #8 revealed she had been assigned to perform pressure ulcer treatments for Resident #7 on 06/24/21. She stated she had been educated to only wear one pair of gloves at a time and perform hand hygiene between glove changes. Nurse #8 further revealed she became nervous</p>	F 880			

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F 880	<p>Continued From page 161</p> <p>while being observed and failed to perform hand hygiene between incontinence care and before beginning the pressure ulcer care as well as after completing the pressure ulcer treatment and exited the room of Resident #7.</p> <p>An interview on 06/24/21 at 4:36 PM with the Director of Nursing revealed she expected Nurse #8 to wear single use disposable use gloves to perform incontinence care and to perform pressure ulcer care and discard them between tasks. The DON explained she expected hand hygiene to be performed between glove changes and she stated Nurse #8 should never don 3 pair of disposable gloves to avoid having to change gloves and perform hand hygiene in an attempt to save time.</p> <p>An interview with the Administrator on 06/25/21 at 2:46 PM revealed he expected all staff to follow universal precautions when performing pressure ulcer care for Resident #7.</p> <p>4. An observation completed on 06/21/21 at 11:42 AM of Resident #23's laundry bag located in Resident #23's room revealed very wet clothing that Resident #23 reported having just come back from the laundry room. Additional review of the laundry bag revealed an incontinence pad that had a very large brown stain in the center and when it was unfolded, 3 pieces of unknown food particles fell on the floor.</p> <p>A review of the facility's policy titled "The Linen Operation" with no revision date revealed the following: "Once linen is sorted into like types (towels and wash clothes, sheets and blankets, personal clothing, kitchen linens, curtains, etc), it is ready to be placed into the washers ...Follow</p>	F 880			

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F 880	<p>Continued From page 162</p> <p>the specifications of the machine, load correctly, and program chemicals according to type of load. Keep in mind machine programming, as some chemicals require hot or cold water to be effective."</p> <p>An observation made on 06/23/21 of the "Formula Chart" for the washing machines in the laundry room revealed personal clothing items to be washed on cycle 2, while incontinence pads were to be washed on cycle 4.</p> <p>During an interview with Laundry Aide #1 on 06/21/21 at 11:49 AM, she reported they had just started washing all of a resident's laundry in a mesh bag in an attempt to keep resident clothing from going missing. She reported Resident #23's laundry bag that contained an incontinence pad along with his personal clothing items should not have been washed together. She reported she must have overlooked that incontinence pad when she threw his laundry bag into the washing machine. She reported if the incontinence pad was washed on the personal belongings cycle, it probably did not come as clean as it should. She reported she would rewashed all of Resident #23's clothes and the incontinence pad separately.</p> <p>During an interview with Environmental Services Director on 06/21/21 at 11:53 AM, he reported that resident personal belongings should not be washed with facility linen or incontinence pads. He reported there were separate wash cycles for those types of linen and the laundry aides needed to ensure that the correct wash cycle was used for each type of linen. He reported they had just started washing all of a resident's laundry in a mesh bag to prevent lost clothing but stated it did</p>	F 880			

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F 880	Continued From page 163 not appear to be a very good practice. An interview with the Administrator on 06/25/21 at 2:45 PM revealed he expected clothing and linen to be washed in accordance with policies and that if there were different wash cycles for personal belongings and incontinence pads, then they should not be washed together.	F 880			
F 921 SS=C	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and facility staff interviews, the facility failed to maintain clean dryer drums free from build-up of melted and hardened substances in dryers for 3 of 3 dryers used to dry linens (dryers #1, #3, and #4). Findings Included: An observation of the facility's dryers completed on 06/21/21 at 11:44 AM revealed dried, multicolored hard substances throughout the entirety of the dryer drum completing a rainbow colored circle approximately 8-12" wide in dryers #1, #3, and #4. An interview with Laundry Aide #1 on 06/21/21 at 11:49 AM revealed the dryer drums have had the dried substances in them as long as she has worked in the building. She reported she did not know what the dried substance was nor was she	F 921	F921 Safe/Functional/Sanitary Environment #1 Replacement dryers ordered on 7/15/21 and replaced on 7/19/21 #2 Dryers to be monitored by EVS director to ensure in good repair and any issues reported to Maintenance Supervisor #3 Dryers will be checked monthly for twelve (12) months to ensure no build up and in good repair. Laundry staff educated by EVS Manager on 7/15/21 to check pockets for items to ensure all items are removed prior to wash/dry. #4 The Administrator will report findings of the monitoring to the Interdisciplinary Team (IDT) during QAPI meetings	7/26/21	

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F 921	<p>Continued From page 164</p> <p>able to determine if it had gotten worse. During the interview, Laundry Aide #1 tried to scrap off the substance without success. She reported 3 of the dryers had unidentified dried, hardened substances in them and verified that the dryers were used for drying resident laundry along with all the linen provided by the facility.</p> <p>During an interview with the Environmental Services Director on 06/21/21 at 11:53 AM, he reported he could not identify the dried, hardened substances that were located in the 3 dryers. He reported he would not want his personal clothing to be dried in the facility's dryers in the condition they were in.</p> <p>During a follow up interview with Laundry Aide #1 on 06/24/21 at 3:23 PM, she reported she had voiced her concern over the condition of the facility's clothes dryers to the previous administration "numerous times" but nothing was ever done. She reported it was difficult to do her job with the condition the dryers were in due to her feeling like the clothes were not clean after being dried in the dryers with the hardened substances in the drums.</p> <p>During an interview with Laundry Aide #2 on 06/24/21 at 5:19 PM, he reported he has worked at the facility in the laundry room for a year and stated the dryer drums have had that dried substance in it since he started working at the facility. He reported he had not notified anyone about the condition of the dryers because "they get hot and dry clothes, so to me, they are working good".</p> <p>During an interview with the Administrator on 06/25/21 at 2:45 PM, he reported Accordius was</p>	F 921	monthly for three (3) months and will make changes to the plan as necessary to maintain compliance.		

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F 921	Continued From page 165 responsible for the maintenance and the servicing of the facility's dryers. He reported his expectation was the dryers be clean, sanitary, and in good operating condition.	F 921		