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	345077	A. BUILDING _____ B. WING _____	C 05/14/2021

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 5/10/21 through 5/14/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #TZ6Y11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 5/10/21 through 5/14/21. Event ID# TZ6Y11. 9 of the 50 complaint allegations were substantiated resulting in deficiencies.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all	F 550		6/7/21

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

Electronically Signed | 06/04/2021

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F 550	Continued From page 1 residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to provide a privacy covering on the urinary bag for 3 of 4 residents reviewed with urinary catheters. (Resident #42, #2, #56) Findings included: 1. Resident #42 was admitted on 4/9/2021, and her diagnoses included chronic kidney disease with heart failure. The Minimum Data Set (MDS) dated 4/15/2021 revealed Resident #42 was severely cognitively impaired and using an indwelling urinary catheter for elimination. Resident #42 ' s care plan dated 4/22/2021 revealed she had an indwelling catheter	F 550	F550-Dignity/privacy covering for urinary catheter bag 1) Identified affected residents: #42, #2, #56 Privacy covers were placed on the urinary bags on 5/12/2021. Orders were reviewed and updated as needed to include documentation of the urinary bag cover on the Treatment Administration Record every shift. 2) Residents having the potential to be affected: Residents with urinary catheters have the potential to be affected. On 5/12/2021 all residents with urinary catheters were assessed for urinary privacy bags. Orders were reviewed and updated as needed to include documentation of the urinary bag cover on the Treatment	

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F 550	Continued From page 2 secondary to obstructive uropathy. Interventions included keeping the drainage bag covered at all times. On 5/11/2021 at 1:18pm, Resident #42 ' s door was open, and the urinary bag was observed facing the hallway with no privacy cover. On 5/11/2021 at 4:05pm, Resident #42 ' s door was open, and the urinary bag with yellow urine was observed without a privacy cover from the hallway. On 5/12/2021 at 8:58am in an interview with NA #4, he stated a privacy bag was used on the urinary bag to provide privacy. On 5/12/2021 at 9:03am, NA #4 stated Resident #42 did not have a privacy bag on the urinary bag, and he would get one for her. On 05/12/2021 at 9:06am in an interview, Nurse #1 stated the facility used covers to provide privacy on the urinary bag, and it was the responsibility of all staff to apply the privacy cover. On 05/12/2021 at 5:01pm in an interview with the Director of Nursing, she stated the facility used blue covers over the urinary bag to provide privacy. On 5/12/2021 at 9:18pm, a privacy cover was observed on Resident #42 ' s urinary bag. On 5/14/2021 at 2:31pm in an interview with the Administrator, he stated urinary bags were to be covered for privacy.	F 550	Administration Record every shift. 3) Staff education was completed on 5/26/21 to include urinary catheter bags to be covered at all times. All residents with urinary catheters will be observed/audited daily X 4 weeks, weekly X 3 and then monthly X 3 to ensure bag covers are present. Re-education will be provided if concerns are observed. 4) Results of audits will be reviewed during QA & A Committee monthly for 3 months. QA & A Committee will review audits and make recommendations based on outcomes. QA & A committee will determine need for further auditing beyond 3 months.	

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F 550	Continued From page 3	F 550		

2. A review of Resident #2's medical record revealed he was admitted to the facility on 12/3/2021 with diagnoses that included nontraumatic hemorrhage and communication deficit.

A review of the most recent Minimum Data Set (MDS) dated 4/28/2021 revealed that Resident #2 had severe cognitive impairment required total care with Activities of Daily Living (ADLS) and had an indwelling urinary catheter.

An observation was conducted on 5/10/2021 at 1:20 PM. Resident #2 was lying in the bed with head of bed (HOB) elevated. The catheter bag was uncovered and had amber colored urine which could be seen from the hallway.

An observation was conducted on 5/11/2021 at 2:33 PM. Resident #2 was positioned on his left side with HOB elevated. The catheter bag was uncovered and had amber colored urine which could be seen from the hallway.

An observation was conducted on 5/12/2021 at 8:48 AM. Resident #2 was positioned on his back with HOB elevated. The catheter bag was uncovered, and urine could be seen from the

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F 550	Continued From page 4	F 550		

hallway.

An interview was conducted with Nurse #1 on 5/12/2021 at 8:54 AM. The nurse stated that catheter bags were supposed to have a privacy cover and staff caring for the resident were responsible for making sure that the privacy cover was in place. The nurse stated that privacy bags were available and kept in the supply room.

An interview was conducted with the Director of Nursing (DON) on 5/13/2021 at 1:10 PM. The DON stated that the urinary bag was always to be covered.

3. Resident #56 was admitted to the facility on 12/7/17 with diagnoses that included hypertension, neurogenic bladder and anxiety.

A review of the quarterly Minimum Data Set (MDS) assessment dated 4/27/21 revealed Resident #56 was severely cognitively impaired and required extensive assistance with toilet use and personal hygiene. The assessment further revealed Resident #56 had an indwelling catheter.

Review of the physician's orders revealed an order dated 12/21/18 for urinary drainage bag covered in privacy bag at all times.

A review of Resident #56's Treatment Administration Record (TAR) revealed an order for drainage bag covered in privacy bag at all times.

Observations on 5/10/21 and 5/11/21 revealed

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F 550	Continued From page 5 the Resident #56's catheter bag did not have a privacy cover, and was visible from the hallway. During an interview with Nurse #1 on 5/12/21 at 9:06AM, she stated covers on catheter bags were provided for privacy. She further stated they were to be on each resident's catheter bag. An interview on 05/12/21 09:32 AM with Nurse Aide (NA) #1 revealed that all catheter bags should have a cover for privacy. NA #1 revealed Resident #56 did not have a privacy cover on the catheter bag. NA #1 stated she was going to place a privacy cover on the resident's catheter bag. During an interview with the Director of Nursing on 5/12/21 at 5:01PM, she stated the facility has privacy blue covers to place over the urinary catheter bag to provide privacy and dignity. She further indicated staff was responsible to ensure the privacy bags were in place.	F 550		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to assess residents for the self-administration of medications for 2 of 2 residents observed to have medications in their rooms (Residents #62 and #59). The findings included:	F 554	F554- Self administration of medications 1) Identified affected residents: #62, #59 Self-administration of medication evaluation was completed for resident #62 by nursing on 5/10/2021. MD orders obtained, Care Plan updated and locked	6/7/21

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F 554	Continued From page 6 1. Resident #62 was admitted to the facility on 4/22/21 and had a diagnosis of psoriasis and pain. Review of the physician's orders revealed the following orders dated 4/22/21: Methyl Salicyclate Lotion 10 percent, apply to irritated areas twice a day for inflammation. Unsupervised, self-administration. Thera-Gesic cream, 1-15 percent, apply to skin topically every 8 hours as needed for pain. Unsupervised, self-administration. Calcipotriene Propionate Cream 0.05 percent. Apply twice a day for psoriasis. Unsupervised, self-administration. The resident's initial Care Plan dated 4/22/21 did not include the self-administration of medications. There was not an assessment of the resident on the medical record to determine if it was safe for the resident to self- administer medications The Admission Minimum Data Set (MDS) Assessment dated 4/28/21 noted the resident was cognitively intact and required limited to extensive assistance with most activities of daily living and was independent with eating. On 5/10/21 at 2:00 PM the resident was observed lying in bed with 3 cups of cream on the overbed table. The Resident stated the hospital discharged him to the facility with the creams and when the nurse first brought him the medications, he told the nurse he had his own creams. The resident was not able to provide the name of the nurse he told. On 5/10/21 an assessment for the administration of medications was done that determined the	F 554	box provided for resident on 5/10/2021. Self-administration of medication evaluation was completed for resident #59 by nursing on 6/1/2021 and MD orders obtained. Care Plan updated and locked box provided for resident on 6/2/2021. 2) Residents having the potential to be affected: On 6/1/2021, all alert and oriented residents were reviewed by the DON, Administrator, and Social Worker for appropriateness of medication self-administration. All residents deemed appropriate were interviewed for the desire to self-administrator medications. None of the identified residents were interested in medication self-administration. 3) Nurse education was completed on 5/20/2021 to include medications are not to be left at the bedside unless there is an order for self-administration. 4) During the admissions review in the morning clinical meeting, the Interdisciplinary team will discuss if the new resident is appropriate for self-administration of medications. If the new admission is deemed appropriate, the DON/Unit Manager/Designee will interview/assess resident for self-administration. Audits will be completed monthly X 3 months by the DON/designee. 5) Results of audits will be reviewed during QA & A Committee monthly for 3 months. QA & A Committee will review audits and make recommendations based on outcomes. QA & A committee will determine need for further auditing beyond 3 months.	

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resident was safe to self-administer the medications.

An entry on the resident's Care Plan dated 5/10/21 noted the following: "At risk for acute/chronic pain related to status post total hip replacement. Cream to reduce pain can be kept at the bedside in lock box and self-administered unsupervised by staff."

On 5/14/21 at 9:45 AM an interview was conducted with the nurse consultant and the Director of Nursing (DON). The Nurse Consultant stated they did not know the resident had the creams in his room until 5/10/21 and when they knew he had the creams in his room they did an assessment for the self-administration of medications and got a lock box for his room to store them in.

2.Resident #59 was admitted to the facility on 8/7/2019 with diagnoses that included COPD, asthma, and malnutrition.

Review of the physician's orders dated 4/29/2021 revealed the following order: Trelegy Ellipta Aerosol Powder Breath Activated 100-62.5-25MCG/INH 1 puff inhale orally one time a day, Lonhala magnair Refill Kit Soution 25MCG/ML 1 inhalation inhale orally 2 times a day, Rewetting Drops Solution- instill 1 unit in both eyes 2 times a day. There was no order for Osteo BiFlex.

The resident's care plan dated 4/14/2021 did not include a focus for self-administration of medications. A review of the resident's medical

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record did not reveal an assessment for the resident to self-administer medication.

The quarterly Minimum Data Set (MDS) Assessment dated 4/28/2021 indicated the resident was cognitively intact and required limited assistance with activities of daily living (ADLS).

On 5/10/2021 at 11:50 AM the resident was observed lying in bed. The resident had a Trelegy Ellipta inhaler, 3 packs of Lonhaler 25mcg/hr inhalation solution, Rewetting Drops, and a bottle of Osteo BiFlex Supplement. The resident stated that the nurses left the medication in his room because they knew he would take them. The resident stated that he took the Osteo BiFlex for his joints to help with movement and preferred to have the eye drops at the bedside due to his dry eyes.

An interview was conducted with Nurse #3 on 5/12/2021 at 8:44 AM. The nurse stated there were no residents on her assignment that self-administered medications. The nurse stated there should be no medications at any of the resident's bedside. The nurse stated that family may have brought in the Osteo BiFlex for Resident #59 and she was not aware of the medication. Nurse #3 removed the medications from the resident's room.

An interview was conducted with the Director of Nursing (DON)on 5/13/2021 at 1:10 PM. The DON stated there were no residents on self-administration of medications. The DON stated that residents had to have a self-administration assessment before they could give themselves medication. The DON further

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F 554	Continued From page 9 stated resident medications should not be left at the bedside.	F 554		
F 584 SS=D	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 in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature	F 584		6/7/21

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F 584	Continued From page 10 levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews and staff interviews, the facility failed to place the resident ' s personal laundry in dresser drawers, remove adult briefs and the bedpan from the top of the resident ' s dresser, and provide a dresser the resident was able to easily open (Resident #17) and provide a clean raised toilet seat (Resident #19) for 2 of 8 residents reviewed for a homelike environment. (Resident #17, Resident #19). Findings Included: 1. The admission Minimum Data Set (MDS) dated 3/9/2021 revealed Resident #17 was cognitively intact, required assistance with all activities of daily living and was always incontinent of urine and stool. On 5/10/2021 at 12:27pm, Resident #17 stated she used the bedpan. On 5/10/2021 at 12:46pm, a gray bedpan with a dry white wash cloth inside and opened packs of adult briefs were observed on a 4-drawer dresser located in the front of Resident #17 ' s room. The dresser drawers were opened approximately three inches and would not move inward or outward. No personal items were observed in the drawers. The drawers were empty except for clean wash linens observed in the third drawer.	F 584	F584-Homelike environment 1) Identified affected residents: #17, #19, #8 #17: On 5/13/2021 a new dresser was placed in the resident□s room. On 5/13/2021 the resident□s briefs were stored in the dresser drawer per resident□s preference. The bedpan was covered and stored in the bathroom. #19: On 5/13/2021 a new raised toilet seat was placed in the resident□s bathroom. #8: On 5/14/2021 the resident□s clothes were hung in the closet by the housekeeping staff. 2) All residents have the potential to be affected Observation/inspection of all resident rooms was completed by the Maintenance Director and Administrator on 6/2/2021. This included: - all dresser drawers in good working order and used appropriately for resident clothing -all raised toilet seats/bedside commodes in good repair with no rusted areas -no bags of clothing on residents floors unless requested by resident -briefs stored in dresser drawers, closets or location requested by resident	

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F 584	Continued From page 11 Resident #17 stated "Can ' t open the drawers, they are broken and need to be fixed. The staff go into the drawers and know the drawers are broken." On 5/11/2021 at 4:09pm a bag of clothes were observed on the floor at the head of the bed. Resident #17 stated the facility had washed the clothes in the bag. She also stated if she was at home, she would have a dresser drawer to put the clothes in. The 4-drawer dresser located in the front of the room was observed with a bedpan laying on top of packs of open adult briefs. The dresser drawers were hard to pull open and would not open more than approximately four inches. On 5/12/2021 at 9:56am in an interview, the laundry supervisor stated she delivered the laundry bag to Resident #17 on 5/11/2021, and Resident #17 told her to leave the bag of clothes on top of the suitcase beside her nightstand beside the bed. On 5/12/2021 at 11:16am, Resident #17 was observed up in her wheelchair in the room and unable to open the first and second dresser drawers. The dresser drawers would not open more than 3 to 4 inches and were not opening and closing properly. The Maintenance Director was present and stated there was a communication book at the nursing station for residents and staff to report items that needed repairing in the resident ' s rooms. He stated the dresser drawers were off track and had not been reported to him. He stated he would fix it. On 5/12/2021 at 11:21am in an interview with Nurse Aide (NA) #4, he stated personal	F 584	-bedpans labeled, covered and stored in bathrooms Any issues/concerns were addressed when observed 3)Housekeeping staff educated by Housekeeping manager on 5/14/2021 to include proper storage of residents clothing. Staff education provided on 5/20/2021-5/26/2021 by DON to include ensuring residents□ homelike environment: -no bags of clothing on residents floors unless requested by resident -briefs stored in dresser drawers, closets or location requested by resident -bedpans labeled, covered and stored in bathrooms -Notify maintenance of issues with furniture or equipment by completing a maintenance request and placing in the maintenance communication book at the nurses□ station. 4)Maintenance Director (or designee in his absence) will take maintenance requests daily to stand up meeting and report to Administrator. Report will be given in stand down to ensure follow up. 5) Weekly room audits will be conducted by the Administrator/designee X 4 weeks and then monthly X 3 months. Results of audits will be reviewed during QA & A Committee monthly for 3 months by the. QA & A Committee will review audits and make recommendations based on outcomes. QA & A committee will determine need for further auditing	

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belongings were placed in the closet and in the dresser drawers, and Resident #17 was always up and going through her belongings. He stated one of the dresser drawers had been off track the last two days, and Resident #17 probably was not able to open the dresser drawers. He stated he had not yet written a ticket for the dresser drawer to be repaired.

On 5/12/2021 at 4:01pm, Resident #17 stated NA #4 had placed her laundry in the dresser drawers, the dresser drawers were fixed, and she was able to open and close the dresser drawers.

On 5/13/2021 at 2:28pm in an interview, NA #4 stated after a bedpan was used, if not thrown away, it was placed under the sink. He stated the bedpan on top of the dresser was not an appropriate place for a bedpan, and adult briefs should be in the closet, not on top of the dresser.

On 5/13/2021 at 3:23pm in an interview, the unit manager stated the bedpan was to be placed in the bathroom and adult briefs were usually in the dresser drawers, but it was the resident ' s choice where to place the adult briefs. She stated, if a bedpan and adult briefs were observed on the top of the dresser, the staff had not cleaned the resident ' s room.

On 5/13/2021 at 4:15pm, two bedpans and open packs of adult briefs were observed on the top of the dresser located at the front of Resident #17 ' s room. A used bedpan was observed under the sink in the bathroom.

On 5/13/2021 at 4:17pm in an interview, NA #5 stated used bedpans were stored in the bathroom, and the bedpans on top of the dresser

beyond 3 months.

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located in the front of the room were new. She stated the bedpan and the adult briefs were not to be visible at all, and the adult briefs needed to be in the dresser drawers. The first and second dresser drawers were observed overlapping and not completely closed. The dresser drawers were difficult to open and close and only opened approximately four inches.

On 5/13/2021 at 4:25pm, the Maintenance Supervisor was observed at the nurse station and informed the dresser drawers in Resident #17 ' s room were off track again. He stated he had a new dresser in the shop and would replace the dresser.

On 5/14/2021 at 10:39am, Resident #17 stated the facility placed a new dresser in the room and the dresser drawers were easy to open. Resident #17 ' s personal clothes were observed in the first two dresser drawers and opened packs of adult briefs were observed on top of the dresser. She stated she would tell the staff to put them in the closet.

On 5/14/2021 at 2:16pm in an interview, the Director of Nursing stated bedpans were usually kept in the bathroom or in one of the dresser drawers, and the adult briefs were stored in a dresser drawer or the closet. She stated staff needed put up the bedpan and adult briefs located on top of the dresser.

On 5/14/2021 at 2:31pm in an interview, the Administrator stated the facility tried to provide what the residents needed and preferred to obtain a home like environment.

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2. An observation on 5/12/21 at 5:05PM revealed the raised toilet seat in Resident #7's bathroom was rusty at the juncture of the crossbars. This rust was significant.

An interview with NA #2 on 5/13/21 at 3:18PM revealed she placed a note in the maintenance communication book when something was in disrepair. NA #2 further stated she had placed a note in the maintenance book regarding disrepair in Resident #7's room several weeks ago.

An interview with Nurse #2 on 5/13/21 at 3:29PM revealed information regarding structural damage to a room or rusty raised toilet seats were logged in the communication book for maintenance. The maintenance department was responsible to address things logged in the communication book.

During a walking interview with the Maintenance Director on 5/13/21 at 3:35PM, he revealed housekeeping was responsible to replace toilet seats. He further stated he would replace the raised toilet set immediately.

A walking interview with the Administrator on 5/13/21 at 3:41PM revealed he expected the Maintenance Department to complete repairs in the facility. He further stated he expected raised toilet seats to be free of rust or disrepair.

3. An observation on 5/14/21 at 10:34AM revealed a plastic bag of clean laundry was placed in the closet of a resident. It was further observed Resident #8 had difficulty in hanging the

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F 584	Continued From page 15 laundry. An interview on 5/14/21 with Resident #8 revealed a laundry staff person had placed a bag of clean laundry in the closet on 5/12/21 and told the resident she would be back on 5/13/21 to hang the clothes up in the closet. Resident #8 stated this had not happened and she was attempting to hang the clothing in her closet. Resident #8 stated she preferred her laundry to be hung in the closet. An interview on 5/14/21 at 10:38AM with the Laundry Supervisor revealed laundry staff was responsible to wash the clothing and return the clean items to the resident. She further stated laundry staff should have asked the resident if they preferred the clothing hung in the closet or folded and placed in the drawer.	F 584		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible	F 644		6/7/21

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F 644	Continued From page 16 serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to submit Pre-Admission Screening and Resident Review (PASARR) assessments before the expiration of the PASARR for 2 of 5 residents reviewed with a PASARR Level II. (Resident #20, #43) Findings include: 1. Resident #20 was admitted to the facility on 3/10/2021, and her diagnoses included Depression, Asperger ' s Syndrome and Schizophrenia. The care plan dated 3/10/2021 revealed Resident #20 used psychotropic medications related to the diagnosis of Schizophrenia, and interventions included the use of medications and monitoring for side effects of the medications. The Minimum Data Set (MDS) dated 3/17/2021 revealed Resident #20 was cognitively intact, exhibited no disruptive behaviors and received antipsychotics on a routine basis daily. The MDS revealed Resident #20 was not currently considered by the state as a Level II PASARR. Resident #20 ' s record review revealed a temporary level II PASARR. On 5/11/2021 at 3:37pm in an interview with the Social Services Director, she stated Resident #20 ' s PASARR II expired on 4/7/2021. She stated the Adult Care FL2 form and the Medication Administration Record (MAR) was submitted on	F 644	F644-Level 2 PASRR expiration 1) Identified affected residents: #20, #43 #20-Clinical information was submitted to NC PASRR for review on 5/27/2021 and level 2 PASRR obtained on 5/28/2021. #43-Clinical information was submitted to NC PASRR for review on 5/12/2021 and level 2 PASRR obtained on 5/13/2021. 2) Residents having the potential to be affected: An audit of all Level 2 PASRR residents was completed on 6/3/2021 by the facility Social Service Director (SSD). Three additional residents noted to have expired Level 2 PASRR□s. Additional information was uploaded to NC MUST to obtain updated PASRR for residents identified with having expired Level 2 PASRR□s on 6/4/2021. 3) Social Service Director and BOM were educated by Administrator on Level 2 PASRR process on 6/3/2021. -PASRR information will be updated on the daily MCA/MGD Tracking sheet by the BOM and discussed in PDPM on any expiring PASRR□s. -SSD or designee will follow up with NCMUST to get new Level 2 PASRR initiated. -Once PASRR initiated SSD or designee will check NCMUST 2-3x/day and update with additional information as requested by NCMUST.	

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F 644	Continued From page 17 4/8/2021. She stated she was new to the Social Services department and the PASARR process. She stated the admission office and business office notified her when the PASARR was expiring so information could be submitted to the North Carolina Medicaid Uniform Screening Tool (NCMUST) system. On 5/11/2021 at 4:19pm in an interview with the Business Office Manager, she stated a temporary PASARR Level II had an expiration date, and Resident #20 expired on 4/7/2021. She stated she started communicating the expiration date in the facility ' s morning team meetings about ten days prior to the expiration date. She stated she ran PASARR reports monthly and highlight the renewal dates but did not provide a copy of the reports for April and May. On 5/12/2021 at 10:10am in an interview with the Admissions Director, she stated the admissions office retained the PASARR Level II number and started the process to retain a certificate from the NCMUST system for residents admitted with a PASARR Level II. She stated PASARRs were discussed at the facility ' s morning meetings, and the renewals and the rescreening process was conducted by the Social Services Department. On 5/12/2021 at 10:54am in an interview with the Administrator, he stated the Admissions Director notified the Social Service Director and the department heads the resident ' s PASARR level on admission. He stated the Business Office Manager monitored PASARR Level II residents and notified the Social Services Department and the staff ten days prior to the PASARR ' s expiration date in the facility ' s morning meetings that included the Administrator, Director of	F 644	4) SSD or designee will perform weekly audits of Level 2 expiring PASRR□s to ensure no expired PASRR weekly X 12 weeks and monthly X 3 months. 5) Results of audits will be reviewed during QA & A Committee monthly for 3 months by the SSD or designee. QA & A Committee will review audits and make recommendations based on outcomes. QA & A committee will determine need for further auditing beyond 3 months.	

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Nursing, Business Office Manager, Unit Manager, MDS Nurse, Admissions Director and Social Services Director. He stated he was not the Administrator at that time Resident #20 ' s PASARR Level II expired and was unable to locate documentation of the facility ' s morning meeting for April 2021.

On 5/12/2021 at 2:00pm in an interview, the Administrator stated the facility had no PASARR for Resident #20. He stated the PASARR Level II had expired and information had been submitted to NCMUST for desk review.

On 5/12/2021 at 3:42pm in an interview, the Administrator stated Resident #20 ' s PASARR Level II expired on 4/7/2021 and the facility had not conducted a follow up.

On 5/14/202 at 9:05am in an interview with the Social Services Director, she stated she did not receive or was aware of the information requested on the PASARR Detail Report on 4/8/2021 at 1:38pm. She further stated she did not know who received those messages.

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2. Resident #43 was admitted to the facility on 3/12/21 with diagnoses of schizophrenia and bipolar disorder.

A review of the significant change Minimum Data Set (MDS) assessment dated 4/16/21 revealed Resident #43 was cognitively impaired and had behavioral symptoms toward others 1 to 3 days of the look back period to include physical behaviors, verbal behaviors, and other behaviors. The assessment further revealed Resident #43 had wandering behaviors for 1 to 3 days of the look back period.

An interview with the Administrator on 5/12/21 at 10:54AM revealed the admissions department was responsible to notify administrative staff of a resident's Pre-Admission Screening and Resident Review (PASARR) number. He further revealed residents with a PASARR Level II were tracked by the Business Office Manager (BOM) and discussed at morning meeting. The Administrator stated the BOM was responsible to notify the social services department when a PASARR was expiring, at that time, the Director of Social Service completed a rescreen process of the PASARR in the North Carolina Medicaid Uniform Screening Tool (NC MUST) system. The Administrator further stated the Director of Social Services was notified 20 days prior to a PASARR expiration date.

During an interview on 5/12/21 at 10:10AM with the Admissions Director, she stated the admissions department obtained a PASARR during the admission process and further retained the PASARR number in the NC MUST system. The Admission Director revealed once the

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F 644	Continued From page 20 resident was admitted, the Director of Social Services was responsible for the renewal and rescreening process of PASARRs. The Admissions Director further revealed the business office was responsible for following up on all PASARRs. An interview with the Director of Social Services on 5/11/21 at 3:37PM, revealed the admission office and business office notified her when a PASARR was expiring so information could be submitted to the NC MUST system. An interview with the Business Office Manager (BOM) on 5/11/21 at 4:19PM revealed communication regarding PASARR's started in morning meeting, this communication included identification of PASARR's with an expiration date The BOM stated she ran a PASARR report monthly which provided a list of PASARR renewal dates. A subsequent interview with the Administrator on 5/12/21 at 3:42PM revealed Resident #43's PASARR temporary Level II had expired on 12/25/19. On 3/18/21 information had been uploaded to the NC MUST system, on 3/19/21, NC MUST requested additional information however, there was no follow up by the facility. The Administrator revealed Resident #43 had no active PASARR number.	F 644		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of	F 657		6/7/21

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F 657	Continued From page 21 the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview the facility failed to update the Care Plan to include interventions for falls for 1 resident (Resident #43), failed to update a resident's Care Plan to include oxygen therapy for 1 resident (Resident #60), for 2 of 43 residents whose care plans were reviewed. The findings included: 1. Resident #43 was admitted to the facility on 3/12/21 and had a diagnosis of traumatic brain injury, cerebrovascular accident (stroke), and difficulty walking.	F 657	F657-Care Plan revision 1) Identified affected residents: #43, #60 #43-Care plan was reviewed for interventions related to resident falls and the revision completed on 5/3/2021 was appropriate. #60-Care plan revision was completed on 5/12/2021 to include oxygen therapy 2) Residents with the potential to be affected: All residents with oxygen therapy care plans were reviewed on 5/12/2021, revisions were made if needed.	

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F 657	Continued From page 22 A Significant Change Minimum Data Set (MDS) Assessment dated 4/16/21 noted the resident required limited assistance with bed mobility, supervision with transfers and when walking in the room or corridor and limited assistance with toileting. The MDS revealed the resident had impaired balance during transfers and was not steady, but able to stabilize without staff assistance. Under range of motion it was noted the resident had impairment of the upper and lower extremities on one side and used a wheelchair for mobility. The MDS noted the resident was occasionally incontinent of urine. The resident's Care Plan dated 3/24/21 noted the resident was at risk for falls due to attempts to self- transfer. The interventions included to ensure gripper socks were worn at all times. Review of documentation for a fall report dated 4/24/21 noted the resident had a small cut on his head and the resident stated he was walking to the bathroom and fell, then got back in bed. There were no other injuries noted. The intervention was to keep a urinal at the bedside to decrease the number of times the resident would get up to go to the bathroom. Review of the nursing assistants' Care Guide noted the resident required moderate assist for toileting with a urinal. The Care Guide nor the Care Plan included the intervention of keeping a urinal at the bedside to limit the number of transfers to go to the bathroom. On 5/13/21 at 3:00 PM Resident #43 was observed lying in bed. There was not a urinal at the bedside.	F 657	An audit of documented interventions for all resident falls for the last 30 days was completed by the MDS nurse. The care plans were reviewed to ensure each fall intervention was listed on the care plans. This was completed on 6/3/2021. 3) Education was completed with the MDS department by the RCD on 6/2/2021. The education included care plan revisions are to be completed in the morning clinical meeting when falls and new orders are reviewed. 4) Weekly care plan audits of residents with falls and new oxygen orders to ensure revisions are completed will be conducted X 4 weeks by the MDS nurse and then monthly X 3 months. 5) Results of audits will be reviewed during QA & A Committee monthly for 3 months. QA & A Committee will review audits and make recommendations based on outcomes. QA & A committee will determine need for further auditing beyond 3 months.	

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F 657	Continued From page 23	F 657		

On 5/14/21 at 9:47 AM, MDS Nurse #1 stated she did not recall the urinal at the bedside being an intervention and was focused on the footwear. The MDS Nurse further stated during the morning meetings they discuss changes and look at the computer and update the Care Plan.

On 5/14/21 at 9:23 AM the Director of Nursing (DON) stated in an interview that interventions were discussed in the morning meetings. The DON further stated the MDS Nurses were present in the meeting and they were supposed to update the Care Plan.

2. Resident #60 was admitted to the facility on 4/21/21 and had a diagnosis of anemia of chronic disease, aortic stenosis and hypoxemia (low oxygen in the blood).

The resident's Care Plan dated 4/22/21 said to observe for hypovolemia or hypervolemia and to monitor for shortness of breath.

The Admission Minimum Data Set Assessment dated 4/27/21 revealed the resident was cognitively intact and required limited to total assistance with activities of daily living.

On 5/5/21 at 1:39 PM a note by the nurse practitioner revealed while working with therapy the resident's oxygen saturation went down to 88 percent on room air. Oxygen saturation up to 92 percent on 2 liters of oxygen.

A nurse practitioner note dated 5/6/21 noted the resident continued to require oxygen since yesterday. Chest X-ray on 5/5/21 showed mild

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F 657	Continued From page 24 bilateral pulmonary edema/infiltrates (possible pneumonia). There were no written physician's orders for oxygen therapy for Resident #60. On 5/10/21 at 11:42 AM Resident #60 was observed lying in bed and was receiving nasal oxygen at 2 liters per minute. There was a physician's order dated 5/12/21 to administer oxygen 1 to 4 liter per minute via nasal cannula to maintain oxygen saturation above 90 percent and to wean as tolerated. There was no information on the Care Plan related to oxygen therapy. On 5/12/21 at 9:47 AM MDS Nurse #1 stated they have morning meetings and discuss changes in a resident's care and the resident's oxygen should have been added to the Care Plan. On 5/14/21 at 9:23 AM the Director of Nursing (DON) stated in an interview that interventions were discussed in the morning meetings. The DON further stated the MDS Nurses were present in the meeting and they were supposed to update the Care Plan.	F 657		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and	F 679		6/7/21

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F 679	Continued From page 25 individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to provide an ongoing structured activities program which met the individual needs of 3 of 3 residents reviewed for activities. (Resident #21, Resident #54, Resident #2) The findings included: 1.Resident #2 was admitted to the facility on 12/3/2020 with diagnoses that included nontraumatic hemorrhage, symptomatic epilepsy, and communication deficit. Resident #2 was coded on the Admission Minimum Data Set (MDS) Assessment dated as 12/9/2020 as severely cognitive impaired and totally dependent on staff for activities of daily living (ADLS). A review of Resident #2's care plan initiated 7/14/2020 revealed no plan of care for activities. An observation of Resident #2 on 5/10/2021 at 1:20 PM revealed the resident to be in bed with the head of bed elevated. There was no one on one activity observed. An observation of Resident #2 on 5/11/2021 at 2:33 PM revealed the resident was positioned on his side and no activities were observed.	F 679	F679-Activities meet interest/needs of each resident 1) Identified affected residents: #2, #54, #21 -Resident #2 was provided 1:1 activity (music therapy) on 5/12/2021 -Resident #54 care plan was updated on 5/12/2021. Activity Director attempted in room activity on 5/13/2021, resident declined. -Resident #21 care plan was updated on 5/13/2021 to include activities of interest, resident offered activities at that time. Activity Director assisted resident with telephone to call family member per resident request. 2)All residents have the potential to be affected -The Activities Director is updating all resident□s activity assessments to include individual needs/interests. To be completed by 6/7/2021. -The Activities Director is updating all residents care plans for activities to meet residents needs. To be completed by 6/7/2021. 3) The Activities Director was educated on 6/1/2021 by the Administrator to include 1:1 activities, in room activities,	

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F 679	Continued From page 26 Review of the Activities documentation from December 2020 to current revealed no information regarding the resident's participation in activities in room, or one on one activities of choice. During an interview on 5/12/2021 at 4:09 PM the Activities Director stated she provided Resident #2 with sensory stimulation activates to include playing music in his room, Zoom calls with his family, set up visits and resident went outside on warmer days. An interview was conducted with the DON and Nurse Consultant on 5/14/2021 at 1:20 PM. The DON stated Resident #2 's wife was very active in the resident's care and one on one activities were provided by the activity staff. 2. Resident #54 was admitted to the facility on 4/8/2016 with diagnoses that included mild cognitive impairment and right and left ankle contracture. Resident #54 was coded on the Significant change MDS Assessment dated 5/6/2021 as moderately cognitively impaired and required extensive assistance with ADLS. A review of the Activities documentation from December 2020 to current revealed no information regarding the resident's participation in activities in room, or one on one activities of choice. An observation of Resident #54 on 5/10/2021 at 1:00 PM revealed the resident to be in the bed with television on.	F 679	care plans, and documentation. 4) The Administrator/Designee will conduct weekly audits of in room activities and activities documentation X 6 weeks, then monthly X 3 months. 5) Results of audits will be reviewed during QA & A Committee monthly for 3 months. QA & A Committee will review audits and make recommendations based on outcomes. QA & A committee will determine need for further auditing beyond 3 months.	

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During an interview with Resident #54 on 5/11/2021 at 9:30 AM she stated there were no activities. The resident stated she was not aware of any in room activities she could do.

An observation of Resident #54 on 5/12/2021 at 3:50 PM revealed the resident to be in the bed with no sensory stimulation nor one on one activities.

During an interview on 5/12/2021 at 4:21 PM the Activities Director stated Resident #54 preferred to be in her room and she was not very big on activities. The Coordinator stated the resident preferred to watch television and listening to staff in the hallway. The Coordinator stated that she goes in the resident's room to talk with her to provide sensory stimulation.

An interview was conducted with the DON and Nurse Consultant on 5/14/2021 at 1:20 PM. The DON stated Resident #54 suffered from chronic pain and would agree to get up on occasion.

3. Resident # 21 was admitted to the facility on 3/16/2021 with diagnoses that included diabetes mellitus, hypertension, and disorders of the veins.

Resident #21 was coded on the Admission MDS Assessment dated 3/21/2021 as cognitively intact and required extensive assistance to total care for ADLS. The MDS further revealed Resident #21 preferred to listen to music she likes, keep up with the news, participate in her favorite activities.

A review of Resident #21's care plan initiated 3/19/2021 revealed no plan of care to meet the resident's activity needs.

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During an interview with Resident #38 on 5/11/2021 at 9:16 AM, she stated she was most interested in getting up out of bed. She added that the staff did not get her up out of the bed and that she stayed in the bed all day. Resident #21 stated staff would tell her they were coming to get her up but never came back.

During an interview with Nursing Assistant #3 on 5/12/2021 at 11: 01 AM and she indicated that Resident #21 often got up in the afternoon. The NA stated the resident required a lift for transfer and 2 staff.

During an observation of Resident #21 5/12/2021 at 3:50 PM she was in bed with head of bed elevated and legs floated on pillows.

During an interview on 5/12/2021 at 4:09 PM the Activities Director stated she provided Resident #2 with sensory stimulation activities to include playing music in his room, Zoom calls with his family, set up visits and resident went outside on warmer days.

An interview was conducted with the DON and Nurse Consultant on 5/14/2021 at 1:20 PM. The DON stated the resident usually got up in the afternoon. The DON stated when staff attempted to get Resident #21 up on 5/13/2021 the Wound nurse was there to see her and stated it was much easier to change the leg dressings while resident was in the bed. The DON reviewed the Point of Care Report for Resident #21 and she had not been up the entire week.

During an interview with the Nurse Consultant and Administrator on 5/14/2021 at 3:10 PM. The Administrator stated that resident should have

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F 679	Continued From page 29 activities provided on a regular basis according to their preferences.	F 679		
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 observation, record review and staff interview the facility failed to document oxygen tubing and humidifier bottle was changed weekly to promote the sanitary delivery of oxygen for 2 of 4 residents reviewed for respiratory care (Residents #48, 60). The findings included: The facility's policy titled Oxygen Administration revised on 5/22/18, did not include information related to the dating or changing of oxygen tubing or humidifier bottles. 1. Resident #48 was admitted to the facility on 4/12/21 and had a diagnosis of acute/chronic respiratory failure, COVID-19 and congestive heart failure (CHF). Review of the physician's orders dated 4/12/21 revealed an order to administer oxygen 2-5 liters to maintain oxygen saturation greater than 90	F 695	F695-Oxygen tubing documentation 1) Identified affected residents: #48, #60 -#48-Oxygen tubing/humidifier bottle changed/dated on 5/12/2021, Treatment Administration Record updated -#60-Oxygen tubing/ humidifier bottle changed/dated 5/12/2021, Treatment Administration Record updated 2) All resident on oxygen therapy have the potential to be affected: On 5/12/2021 all residents with oxygen therapy were reviewed. Tubing and humidifier bottles changed and dated. All orders reviewed and updated if needed, Care Plans reviewed and updated as needed, Treatment Administration Records reviewed and updated as needed. 3) Nursing education provided 5/20/2021-5/25/2021 to include 11-7 staff to change bottle and tubing Sunday	6/7/21

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F 695	Continued From page 30 percent. The resident's comprehensive Care Plan dated 4/22/21 revealed the resident was on chronic oxygen therapy related to COPD (Chronic Obstructive Pulmonary Disease) and to monitor for signs and symptoms of respiratory distress. The resident has oxygen via nasal prongs. On 5/10/21 at 4:40 PM the resident was observed to be sitting in a wheelchair in her room. The resident was observed to have oxygen being delivered at 2 liters per minute by nasal prongs. There was no date observed on the tubing or the humidification bottle. On 5/12/21 at 11:15 AM the Director of Nursing (DON) stated in an interview that on Sunday nights the third shift nurses change the oxygen tubing and water bottles and documents this on the Treatment Administration Record (TAR). On 5/12/21 at 4:00 PM, review of the resident's TAR for May 2021 revealed no entry to change the oxygen tubing and humidifier bottle weekly. On 5/12/21 at 5:45 PM the resident was observed sitting in her room eating supper. The resident was receiving nasal oxygen at 2 liters per minute. There was no date observed on the tubing or the humidifier, On 5/12/21 at 7:35 PM there were physician's orders to change the oxygen tubing and humidifier weekly every night shift every Sunday starting 5/16/21 and the order had been entered on the resident's TAR. On 5/14/21 at 9:00 AM an interview was	F 695	nights. Also nursing staff to ensure new and dated tubing and bottles for new/re-admits. 4) Audits will be completed weekly on Mondays X 6 weeks and then monthly X 3 months. 5) Results of audits will be reviewed during QA & A Committee monthly for 3 months. The QA & A committee will review audits and make recommendations based on outcomes. QA & A committee will determine need for further auditing beyond 3 months.	

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F 695	Continued From page 31	F 695		

conducted with the Director of Nursing (DON) and the nurse consultant the staff development coordinator (SDC). The Nurse Consultant stated the oxygen tubing and the humidifier bottle was changed by the night shift staff on Sunday nights and the tubing and bottle were dated on the lip of the tubing where it connects to the humidifier bottle and was sometimes hard to see.

On 5/14/21 at 9:35 AM an observation of the resident's tubing and water bottle was conducted with the staff development coordinator (SDC). The tubing and bottle were both dated 5/12/21 (Wednesday).

On 5/14/21 at 10:20 AM the SDC stated the nurse that confirmed the physician's orders was responsible for entering the order on the TAR to change the tubing and humidifier bottle weekly on Sundays on night shift.

2. Resident #60 was admitted to the facility on 4/21/21 and had a diagnosis of anemia and hypoxemia (low oxygen in the blood).

The Admission Minimum Data Set (MDS) Assessment dated 4/27/21 revealed the resident was cognitively intact, required limited to total assistance with activities of daily living. There was no information on the MDS that the resident received oxygen therapy.

On 5/10/21 at 11:42 AM Resident #60 was observed lying in bed with oxygen delivered at 2 liters per minute via nasal cannula. There was not a date on the oxygen tubing or the humidification bottle.

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F 695	Continued From page 32	F 695		

On 5/12/21 at 9:06 AM the resident was observed sitting on the side of the bed in the room and was observed to receive oxygen at 2 liters per minute via nasal cannula. There was not a date on the tubing or the humidification bottle.

The Director of Nursing stated in an interview on 5/12/21 at 11:15 AM that the nurse on third shift on Sunday nights was supposed to change the humidifier and oxygen tubing and document this on the Treatment Administration Record (TAR).

Review of the resident's TAR revealed no entry to change the oxygen tubing and water bottle on Sundays on night shift.

There was a physician's order dated 5/12/21 for 1-4 liters per minute of oxygen per nasal cannula to maintain saturations greater than 90 percent. Wean as tolerated.

On 5/14/21 at 9:36 AM an interview was conducted with the Director of Nursing (DON) and the nurse consultant. The DON stated the oxygen and tubing was changed by the nurse on Sundays on night shift and the date was put on the lip of the oxygen tubing and was sometimes difficult to see.

On 5/14/21 at 9:30 AM an observation of the resident's tubing and water bottle was conducted with the staff development coordinator (SDC). The tubing and bottle were both dated 5/12/21 (Wednesday).

On 5/14/21 at 10:20 AM the SDC stated the nurse that confirmed the physician's orders was responsible for entering the order on the TAR to change the tubing and humidifier bottle weekly on

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F 695	Continued From page 33 Sundays on night shift.	F 695		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to store narcotics in a locked permanently affixed compartment for 1 of 1 store rooms checked for medication storage and facility failed to discard expired medication for 2 of 2 medication carts (Cart 1, Cart 4) reviewed for medication storage.	F 761	F761 Drug Storage/expired biologicals/permanently affixed scheduled 2 meds in refrigerator 1) No identified affected residents 2) All residents have the potential to be affected. All of the facility medication carts	6/7/21

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F 761	Continued From page 34 The findings included: A review of the facility policy titled, "Storage and Expiration Dating of Medications, Biologicals" with an effective date of October 2016, read in part: Store all drugs and biologicals in locked compartments, including storage of Schedule II-V medications in separately locked, permanently affixed compartments. The policy further stated, "if a multidose vial of an injectable medication has been opened or accessed, the vial should be dated and discarded within 28 days and the facility should ensure that medications and biologicals have an expired date on the label and are stored separately from other medications until destroyed or returned to pharmacy." 1.During an observation of the medication storage room labeled as Medication Room #2 on 5/13/2021 at 3:35 PM, the narcotic lock box was inside a refrigerator that was unlocked. The narcotic lock box was not permanently affixed to refrigerator and was removeable. An interview with the Director of Nursing and Nurse Consultant on 5/13/2021 at 3:50 PM revealed that the refrigerators had recently been changed out and the narcotic box had been permanently affixed to the refrigerator. 2. During an observation of the medication cart #1 for medication storage on 5/14/2021 at 1:06 PM, 1 opened and accessed bottle of sterile normal saline with an opened date of 5/7/2021 was in the bottom drawer, and an opened bottle of Liquid Pain Relief 160mg/5ml with an expiration date of 12/2020. Nurse #1 immediately removed the normal saline and Liquid Pain Relief	F 761	were inspected for expired medications on 5/14/2021. The narcotic box in the medication room refrigerator was replaced with one that is attached to the inside of the refrigerator on 6/3/2021. 3) Nursing education provided 5/20/2021-5/25/2021 to include medication cart audits every Monday and Thursday nights. The audits were added to the 11-7 shift task list/book at the nurses stations. 4) DON/designee will perform a refrigerator audit to ensure the narcotic box is permanently affixed and medication cart audits weekly X 6 weeks, then monthly X 3 months. 5) Results of audits will be reviewed during QA & A Committee monthly X 3 months. QA & A Committee will review audits and make recommendations based on outcomes. QA & A committee will determine need for further auditing beyond 3 months.	

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F 761	Continued From page 35 to be discarded. An interview was conducted with Nurse #1 on 5/14/2021 at 1:15 PM. Nurse #1 stated it was the nurse administering the medication's responsibility to check the expiration dates of medication. An interview with the DON and Nurse Consultant on 5/14/2021 at 1:20 PM revealed that the nurse on the cart was responsible for making sure that medications were not expired. The DON stated that expired medications should be removed from the cart and discarded.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 812		6/7/21

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	345077	A. BUILDING _____ B. WING _____	C 05/14/2021

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F 812	Continued From page 36 Based on observations, policy review and staff interviews the facility failed to maintain kitchen equipment clean and in a sanitary condition to prevent cross contamination by failing to clean six of six baking sheets, failed to clean one of one lowerators and failed to clean under the shelf of one of one steam table observed and for one of one staff who failed to wear a beard net during meal service. The findings included: 1. During a kitchen observation on 5/12/21 at 9:34 AM six baking sheets were observed stacked and ready for use. The baking sheets were observed to have 1/8 inch to ¼ inch of black dried food residue a half inch wide under the rim. During the meal plating observation on 5/12/21 at 12:12 PM the five well steam table was observed. The twelve-foot underside of the steam table shelf was observed to be covered with dark dried food particles. The heating element that hung over the 5 steam wells was observed to have dark dried food particles stuck on the heating element wires. During a kitchen observation on 5/13/21 at 9:22AM the lowerator (A two-cylinder spring loaded plate dispenser) plate dispenser was observed. One of the cylinders was observed with dried food particles, on the bottom. On 5/14/21 at 9:01AM an observation of the kitchen was made with the dietary manager. The lowerator, steamtable undershelf and six baking sheets were in the observed to be in the same condition as described above. In an interview on 5/14/21 at 9:05 AM the Dietary	F 812	F812Food procurement 1) No identified affected residents 2) All residents have the potential to be affected. -6 of 6 baking sheets were discarded on 5/13/2021 and new baking sheets were ordered on 5/17/2021. -1 of 1 lowerator was cleaned and added to the weekly cleaning schedule on 5/13/2021. - 1 of 1 tray line shelf was cleaned on 5/14/2021 and again on 6/4/2021. - All kitchen staff was educated on use of beard net on 5/13/2021. 3) -Staff educated to inform Dietary Manager or Dietary Assistant of any kitchen supplies that need replacement. -Staff educated on addition of lowerator to weekly cleaning schedule. -Steam table shelf tray line is clean and free of food debris. Staff has been educated on addition of cleaning tray line shelf according to cleaning schedule. -All staff was educated on use of beard guards on 5/13/2021 4) -Dietary manager or designee will perform weekly audits of baking sheets to ensure good quality 1x/week X 8 weeks and then monthly X 3 months. -Lowerator was added to the weekly cleaning schedule on a permanent basis. Dietary manager or designee will audit cleanliness of lowerator weekly x 8 weeks and monthly X 3 months. -Tray line shelf was added to a permanent tray line cleaning schedule weekly to	

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F 812	Continued From page 37 Manager revealed the lowerater and steamtable undershelf were not on the cleaning schedule. He stated staff should clean the lowerater, steamtable and baking sheets and he would add those areas to the cleaning schedule. 2. During the kitchen observation on 5/12/21 at 12:12PM the cook was observed plating up the meal. The cook wore a face mask and was observed to have an uncovered two-inch beard that protruded below his face mask. On 5/13/21 at 11:55 AM the cook was observed preparing the meal, he wore a face mask and was observed to have an uncovered two-inch beard that protruded below his face mask. In an interview on 5/13/21 at 12:00 PM the cook stated he normally kept his beard trimmed and his face mask would cover his beard. He stated he was taught to wear a beard net and forgot that day to wear a beard net. The cook indicated beard nets were available in the diet office and he proceed to don a beard net. In an interview on 5/13/21 at 12:01 PM the Dietary Manager stated the male cook should wear a beard net and beard nets were available for use.	F 812	include under the shelf. Dietary manager or designee will audit cleanliness of tray line shelf weekly x 8 weeks and monthly X 3 months for cleanliness of tray line shelf. -Random weekly audits X 12 weeks will be conducted by the Dietary Manager or designee to validate staff is following proper policies and wearing beard net. 5) Results of audits will be reviewed during QA & A Committee monthly for 3 months by Dietary manager or designee. QA & A Committee will review audits and make recommendations based on outcomes. QA & A Committee will determine need for further auditing beyond 3 months	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable	F 880		6/7/21

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F 880	Continued From page 38	F 880		

diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility

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F 880	Continued From page 39 must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interviews, and review of Centers for Disease Control Prevention (CDC) guidelines for Responding to COVD-19 in Nursing Homes the facility failed to implement CDC guidelines when staff did not perform hand hygiene between residents for 2 of 4 residents(Resident #21, Resident #54) during meal observation. The findings included: The CDC guideline titled "Responding to Coronavirus (COVID-19) in Nursing Homes" and dated 3/29/2021 read in part: Removes gloves after contact with resident and/or surrounding environment using proper techniques to prevent hand contamination.	F 880	F880-Infection Prevention/Control/Hand hygiene 1) In review of the F880 deficiency related to Hand Hygiene/Hand Washing. 2) On 6/1/21 the center employed the 5 whys Method of Root Cause Analysis and determined the following to be the root cause. The center failed to implement hand hygiene and follow the process outlined in the facility policy Hand Washing/Hygiene. Review of the identified CNA revealed that the staff member has completed education and competencies related to hand hygiene throughout her tenure in the center. Interview with identified CNA revealed that	

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F 880	Continued From page 40 On 5/10/2021 at 12:02 PM Nursing Assistant (NA) #5 was observed setting up Resident #54' s meal tray. The NA exited the room without performing hand hygiene and proceeded to the meal tray cart. The NA retrieved a meal tray from the cart. On 5/10/2021 at 12:07 PM NA #5 was observed to carry a meal tray to Resident #21. The NA did not perform hand hygiene prior to delivering the meal tray. The NA placed the meal tray on Resident #21's bedside table, repositioned the resident and readied the meal tray. The NA exited the room. An interview was conducted with NA#5 on 5/10/2021 at 12:10 PM. The NA stated she did not wash her hands between residents unless she touched resident's personal items. During an interview with the Director of Nursing (DON) and the Nurse Consultant on 5/13/2021 at 1:10 PM she stated that staff are to wash their hands before entering a resident's room and after leaving a resident's room. The DON stated the staff should wash their hands between resident to resident care.	F 880	the staff member has completed education and competencies related to hand hygiene. The staff member relates she did not have understanding that even though she did not touch residents personal items hand hygiene is still required. The center has resolved this issue by providing immediate re-education to identified CNA regarding the requirements for hand hygiene. From 5/10/21 to 5/26/21. The RN DON/Interim IPCO has provided ongoing re-education and competencies to center staff on proper hand hygiene. 1. CMS Targeted COVID 19 Training for Frontline Nursing Home Staff completion of Frontline staff which is on-going as newly hired staff are required to complete within 5 days of hire. As of 6/1/2021 all facility staff have completed the training. 2. Re-education of Hand Hygiene/Hand Washing with observed competency completed by RN DON, RN Supervisor and LPN Support by 6/7/21. 3. Random weekly audits will be conducted by the DON/Interim RN IPCO/ Designee to validate that staff are following proper Hand Washing/Hand Hygiene procedures. 4. Results of audits will be reviewed during QA & A Committee monthly for 3 months by DON/ IPCO/ designee. QA & A Committee will review audits and make recommendations based on outcomes.	

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F 880	Continued From page 41	F 880	QA & A Committee will determine need for further auditing beyond 3 months	