STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345223	A. BUILDING _____ B. WING _____	C 07/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIDGE HEALTH AND REHABILITATION CENTER	1510 HEBRON STREET HENDERSONVILLE, NC 28739

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification survey and complaint investigation were conducted on 06/28/21 through 07/01/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# MOXS11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification survey and complaint investigation were conducted on 06/28/21 through 07/01/21. There were three allegations investigated and one was substantiated. Event ID# MOXS11.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.	F 583		8/6/21

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

Electronically Signed | 07/26/2021

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F 583	Continued From page 1 §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to protect the Private Health Information (PHI) for 3 of 3 residents (Resident #2, #35 and #69) by leaving confidential medical information unattended and exposed in an area accessible to the public on 1 of 4 medication carts. Findings included: A continuous observation of an unattended medication cart on the East Wing of the 100 Hall was made on 6/30/21 from 12:18 PM through 12:22 PM. Nurse #1 left the medication cart with the computer screen visible while she administered medication in room 107, approximately 30 feet away. Resident's # 2, # 35, and # 9's PHI, which included pictures, room numbers, and list of medications were visible. Other residents, staff, and visitors were present on the hall. The unattended computer screen was accessible to anyone who passed by, including those who were not authorized to view this confidential information.	F 583	F583 This alleged deficiency was caused by a licensed nurse's failure to follow policies and procedures related to personal privacy and confidentiality of medical records. How will corrective action be accomplished for those residents found to have been affected by the deficient practice: Nurse #1 was re- educated on 6/30/21 by the Director of Nursing on the facility's privacy practices. Other licensed nurses and Resident Care Specialists (C.N.A's) were also educated on this requirement by the Director of Nursing on 6/30/21. Privacy covers were added to the laptop computers used by the nurses to cover personal information and the nurses were educated to flip them over the screen when they walk away from the computers. How will corrective action be accomplished for those residents having	

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F 583	Continued From page 2 Interview with Nurse # 1 at 12:22 PM on 6/30/21 revealed she was providing another resident medication while the computer screen was left unattended and resident PHI was visible. Nurse # 1 stated she intended for the screen to be locked and thought she had locked it. Nurse # 1 stated she had received training on standards to protect resident PHI and the computer screen information should not have been left visible. Interview with the Nurse Manager (NM) at 12:27 PM on 6/30/21 revealed nursing staff were expected to lock computer screens when leaving them unattended, to protect resident confidential health information. The NM stated nursing staff receive annual training on the protection of resident PHI. Interview with the Director of Nursing (DON) at 12:50 PM on 6/30/21 revealed her expectation was for nursing staff to lock their computer screens and resident PHI from view, when left unattended. The DON stated a computer icon alerts the nurse when the screen has been appropriately locked, and nursing staff received annual Health Insurance Portability and Accountability (HIPAA) training. Interview with the Administrator at 10:31 AM on 7/1/21 revealed staff receive annual HIPPA training, in addition to HIPPA training upon hire. The Administrator stated it was his expectation that Nurse # 1 keep resident PHI private.	F 583	the potential to be affected by the same deficient practice: Nurse #1 was re- educated on 6/30/21 by the Director of Nursing on the facility's privacy practices. Other licensed nurses and Resident Care Specialists (C.N.A's) were also educated on this requirement by the Director of Nursing on 6/30/21. Privacy covers were added to the laptop computers used by the nurses to cover personal information and the nurses were educated to flip them over the screen when they walk away from the computers. Other licensed nurses, Resident Care Specialists and contracted agency staff will be in-serviced by the Director of Nursing, Infection Preventionist/ ADON, Unit Manager(s) or other designated nursing staff member on or before 8/6/21 on the facility's privacy practices, including covering personal information on nursing computers and using the privacy covers. What measures will be put into place or systematic changes made to ensure the deficient practice does not recur: Other licensed nurses, Resident Care Specialists and contracted agency staff will be in-serviced by the Director of Nursing, Infection Preventionist/ ADON, Unit Manager(s) or other designated nursing staff member on or before 8/6/21 on the facility's privacy practices, including covering personal information on nursing computers and using the privacy covers.	

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F 583	Continued From page 3	F 583	How the corrective actions will be monitored to ensure the practice will not recur, i.e. what Quality Assurance program will be put into place: To ensure ongoing compliance, the Director of Nursing, Infection Preventionist/ ADON, Unit Manager(s) or other designated nursing staff member will inspect nursing computers to ensure privacy is maintained using an audit tool three (3) times a day for four (4) weeks, then twice daily for two (2) weeks and then daily for two (2) weeks until compliance has been determined. Any identified non- compliance will be corrected immediately with re-education provided as necessary. The results of these audits will be reported at the monthly QAPI meeting until such time substantial compliance has been achieved. Systems Review. The Director of Nursing is responsible for implementing the acceptable plan of correction. Completion Date 8/6/21.	
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	F 584		8/6/21

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F 584	Continued From page 4 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 levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to ensure the walls in resident rooms	F 584	F584	

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F 584	Continued From page 5 were free from holes, peeling wall board, and missing baseboard in 3 of 21 rooms (Room #102, Room #128 and Room # 221), the wall had no torn wall board, detached wall tiles, missing paint, and damaged sheetrock in 4 of 16 bathrooms (Bathroom #109, shared Bathroom #111/113, Bathroom # 122, and Bathroom #219), the toilet paper holders had no missing parts in 3 of 16 bathrooms (shared Bathroom #106/108, shared Bathroom #111/113, and Bathroom #114), and the towel bars had no missing parts in 2 of 16 bathrooms (shared Bathroom #106/108 and shared Bathroom #111/113). Findings included: 1. a. An observation of the shared bathroom of Room #106/108 on 06/28/21 at 9:55 AM revealed one side of the metal holder for the toilet paper holders was missing. In addition, the metal rod of the towel bar was missing. Additional observations conducted of the shared bathroom of Room #106/108 on 06/29/21 at 9:22 AM, and 06/30/21 at 3:42 PM revealed the toilet paper holder and the towel bar remained unchanged. b. An observation of the bathroom of Room #109 on 06/28/21 at 10:34 AM revealed the wall behind the hand soap dispenser was torn approximately 2 by 8 inches. 3 nail holes with diameter of approximately 0.25 inches were noted inside the torn areas. Additional observations conducted of the bathroom of Room #109 on 06/29/21 at 5:11 PM, and 06/30/21 at 3:45 PM revealed the walls remained unchanged. c. An observation of the shared bathroom of	F 584	This alleged deficiency was caused by staff members failure to follow established policies and procedures related to inspecting resident rooms and reporting necessary maintenance issues and correcting issues as identified. How will corrective action be accomplished for those residents found to have been affected by the deficient practice: The Maintenance Director and/ or a qualified contractor will take the following corrective action for the identified issues: " The toilet paper holder in the shared bathroom of rooms 106/ 108 will be replaced and the towel bar removed as these are no longer used. " The damaged wall in the bathroom of room 109 will be repaired. " The toilet paper holder in the shared bathroom of rooms 111/ 113 will be replaced and the damaged wall repaired. " The towel bar in the shared bathroom of rooms 111/ 113 will be removed as these are no longer used. " The damaged wall behind the bed in room 102 and the hole in the wall behind the entry door to this room will be repaired. " The toilet paper holder in the bathroom of room 114 will be replaced. " The detached wall tiles above the tub in room 122 will be repaired. " The missing cove base below the heating & air conditioning unit in room 221 will be replaced.	

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F 584	Continued From page 6 Room #111/113 on 06/28/21 at 11:22 AM revealed both sides of the metal holder for the toilet paper holders and the metal rod of the towel bar were missing. In addition, there was a crack approximately 1.5 by 5 inches at the lower left corner of the wall in the bathroom. Additional observations conducted of the shared bathroom of Room #111 on 06/29/21 at 5:18 PM, and 06/30/21 at 3:47 PM revealed the toilet paper holders, towel bar, and the walls remained unchanged. d. An observation of the bedroom of Room #102 on 06/28/21 at 1:43 PM revealed multiple spots of peeling sheetrock approximately 12 by 24 inches on the walls behind the bed by the window. In addition, the wall behind the entrance door about 48 inches above the floor was noted with a round hole approximately 2 inches in diameter. Additional observations conducted of the bathroom of Room #102 on 06/29/21 at 4:35 PM, and 06/30/21 at 2:21 PM revealed the walls remained unchanged. e. An observation of the bathroom of Room #114 on 06/28/21 at 1:53 PM revealed one side of the metal holder for the toilet paper holders was missing. Additional observations conducted of the bathroom of Room #114 on 06/29/21 at 11:35 AM, and 06/30/21 at 2:45 PM, and 07/01/21 at 2:50 PM revealed the toilet paper holders remained unchanged. An interview and tour were conducted with the Maintenance Director (MD) and the Administrator on 07/01/21 at 3:51 PM that revealed the observations conducted of Rooms 102, 106, 109, 111, and 114 remained unchanged. The MD	F 584	" The scraped wall behind the bed in room 219 will be repaired. " The damaged sheet rock on the wall behind the bed in room 128 will be repaired. The black colored debris around the base of the toilet in the shared bathroom of 219/ 221will be cleaned by Housekeeping and the toilet repaired as necessary. All issues identified by the survey team will be corrected on or before 8/6/21. How will corrective action be accomplished for those residents having the potential to be affected by the same deficient practice: An inspection of other resident rooms and resident bathrooms was completed by the Administrator on 7/23/21 to determine if there were other broken or missing toilet paper holders or towel bars, holes in walls, damaged tiles, debris around toilets, and/ or damaged sheetrock. Those identified will be repaired, replaced or cleaned as necessary by Housekeeping, the Maintenance Director, or other contractor on or before 8/6/21. What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur: To ensure that this deficient practice does not recur, facility staff and contracted staff will be educated by the Administrator or Maintenance Director on or before 8/6/21 on the process for reporting maintenance	

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F 584	Continued From page 7 indicated the facility utilized an electronic work order entry system. He checked the work orders at least once every 2-3 days. He did not have a routine walk-through to check the facility for maintenance needs. Most of the repair needs were communicated by the staff through verbal communication. He prioritized work order requests based on safety concerns. The MD explained his workload was heavy with only one person working in the maintenance department. The facility had tried to hire one additional staff for maintenance department and contract with outside contractor to assist with painting and repairs, but the attempts had not been successful at this time. During an interview with the Administrator on 07/01/21 at 3:51 PM, he confirmed the areas of concern identified during the tour needed to be fixed immediately. It was his expectation for all the residents to have a safe and homelike environment that was in good repair. 2.a. An observation of Room #122 on 06/28/21 at 10:34 AM revealed 4 detached wall tiles above the bathtub of a bathroom. An observation on 07/01/21 at 3:49 PM of Room #122 revealed no change in the appearance of the tiles above the bathtub. b. An observation of Room #221 on 06/28/21 at 10:51 AM revealed a missing section of baseboard underneath a wall heating and cooling unit. In the bathroom a large amount of dried, black colored debris surrounded the base of the toilet. An observation on 06/30/21 at 2:37 PM of Room #221 revealed no change in appearance of the baseboard or black debris around the base of the toilet.	F 584	or housekeeping issues including broken toilet paper holders and towel bars, debris around toilets, holes in walls, damaged tiles, and damaged walls. This education will include the designated staff members who participate in the Ambassador Program currently in effect at the facility. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: To ensure ongoing compliance, the Administrator, Director of Nursing, Infection Preventionist/ Assistant Director of Nursing, Unit Managers, or Department Managers will audit ten (10) resident rooms per week for four (4) weeks and monthly thereafter for two (2) months using an audit tool to determine if there are any broken toilet paper holders and towel bars, debris around toilets, holes in walls, damaged tiles, or damaged walls. In addition, the Housekeeping Manager or Manager in Training will audit ten (10) resident room bathrooms per week for four (4) weeks and monthly thereafter for two (2) months using an audit tool to determine if there any toilets with noticeable discoloration or debris present around the base. Any concerns identified will be brought to the Housekeeping Supervisor and Maintenance Director as appropriate for corrective action to be taken. Findings will be reported at the monthly QAPI meeting until such time substantial	

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F 584	Continued From page 8 c. An observation of Room #219 on 06/28/21 at 10:56 AM revealed 4 areas of missing paint and scrape marks on the wall behind the bed. A second observation of Room #219 on 06/30/21 at 2:35 PM revealed no change in the appearance of the wall behind bed. d. An observation of Room #128 on 06/28/21 at 4:07 PM revealed 3 large areas of missing paint and damaged sheet rock to the wall behind the bed. A second observation of Room #128 on 07/01/21 at 3:51 PM revealed no change in the appearance of the wall behind the bed. An interview and walk-through to reveal areas of concern were conducted with the Maintenance Director and Administrator on 07/01/21 at 3:51 PM. The Maintenance Director explained he checked the electronic work order system used by staff to notify him of maintenance concerns approximately every 2 to 3 days. He also relied on Ambassador round observations to identify maintenance concerns and was in resident rooms once a week. The rooms needed repair but he had to prioritize work order requests based on safety concerns and explained attempts to hire maintenance personnel hadn't worked out nor attempts to hire an outside contractor to assist with painting and repairs. During an interview on 07/01/21 at 3:59 PM the Administrator confirmed the areas of concern during the walk-through needed repair. The Administrator revealed it was his expectation residents had a safe, homelike environment that was in good repair.	F 584	compliance has been achieved. This plan of correction will be implemented by the facility Administrator. Completion Date 8/6/21.	
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On	F 756		8/6/21

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F 756	Continued From page 9 CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that	F 756		

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F 756	Continued From page 10 requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff, Pharmacy Consultant, and Nurse Practitioner (NP) interviews the facility failed to implement an ordered pharmacy recommendation for 1 of 5 residents (Resident #56) reviewed for unnecessary medications. Findings included: Resident #56 was admitted to the facility 05/20/21 with diagnoses including non-Alzheimer's dementia. Review of the admission Minimum Data Set (MDS) dated 05/27/21 revealed Resident #56 was severely cognitively impaired. Review of Physician's orders dated 05/20/21 revealed an order for fluticasone propionate (a corticosteroid nasal spray) 50 micrograms (mcg)/ actuation (act) 2 sprays in both nostrils two times a day for nasal congestion. Review of a Pharmacy Consultation Report dated 05/21/21 revealed Resident #56's order for fluticasone propionate 50mcg/act 2 sprays in both nostrils twice a day exceeded the manufacturer's recommended maximum daily dose of 2 sprays in each nostril (total daily dose of fluticasone propionate being 200 mcg). The Pharmacy Consultation Report was signed by the NP on 05/24/21 as agreeing with the pharmacy recommendation to decrease fluticasone propionate to 200 mcg daily. Resident #56's May 2021 and June 2021	F 756	F756 This alleged deficiency was caused by an RN Unit Manager failing to completely transcribe a pharmacy recommendation. How will corrective action be accomplished for those residents found to have been affected by the deficient practice: The nurse practitioner (NP) for resident #56 was notified and Unit Manager #1 obtained a new order on 6/30/21 in accordance with the pharmacy recommendation. How will corrective action be accomplished for those residents having the potential to be affected by the same deficient practice: A review of pharmacy orders obtained on 6/24/21 for other residents will be completed by the Unit Manager(s) on or before 7/28/21 to determine if other orders were missed. Any identified issues will be corrected immediately by the Unit Managers, Director of Nursing, or Infection Preventionist/ ADON. What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur: The Pharmacy Consultant provided in-service education to the Director of	

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F 756	Continued From page 11 Medication Administration Records (MARs) revealed he received fluticasone propionate 50 mcg/act 2 sprays both nostrils twice a day. An interview with the Director of Nursing (DON) on 06/30/21 at 01:27 PM revealed pharmacy conducted medication reviews upon admission and monthly thereafter. She explained the Pharmacy Consultant emailed his recommendations to her and she passed them on to the provider. The DON stated if the provider agreed with the pharmacy recommendation the provider signed the recommendation and she gave the recommendation to the Unit Manager on the unit where the resident resided. She stated the Unit Manager updated the resident's orders to reflect changes in the resident's medication. The DON stated the pharmacy consult recommendation decreasing the fluticasone propionate to 200 mcg daily signed by the NP on 05/24/21 should have been entered in the computer as a new order on 05/24/21 and the order was missed. An interview with Unit Manager #1 on 06/30/21 at 02:18 PM revealed she did not recall receiving the signed pharmacy recommendation to decrease Resident #56's fluticasone propionate from 400 mcg daily to 200 mcg daily. She explained the usual process after the provider signed the pharmacy consult as agreeing with the recommendation the new order was entered in the computer by the DON, a Unit Manager, or any nurse receiving the order. She stated Resident #56's order to decrease his fluticasone propionate was missed. An interview with the Pharmacy Consultant on 07/01/21 at 09:48 AM revealed the initial order for	F 756	Nursing, Unit Managers, and Infection Preventionist/ ADON on 7/23/21 on the process for completing pharmacy recommendations to ensure new orders are properly transcribed. The Physican/NP after signing a pharmacy recommendation, will return the recommendation to the Unit Manager for transcription. The DON/designee will follow up to ensure the orders have been transcribed appropriately. The DON/designee will match transcribed orders with a checklist provided by the pharmacist to ensure all recommendations have been completed appropriately. How the corrective actions(s) will be monitored to ensure the practice will not recur, i.e. what quality assurance program will be put into place: To ensure ongoing compliance, the Unit Manager(s) will review with the Director of Nursing or Infection Preventionist/ ADON weekly any new admission pharmacy recommendations for proper transcription and monthly for all pharmacy recommendations. The Director of Nursing or Infection Preventionist/ ADON will maintain copies of the drug regimen review for eight (8) weeks to ensure accuracy of the recommendations. Any discrepancies identified will be corrected immediately with re-education provided as necessary. The audits will be monitored weekly ensuring that all recommendations were	

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	345223	A. BUILDING _____ B. WING _____	C 07/01/2021

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F 756	Continued From page 12 fluticasone propionate to receive a total of 400 mcg daily exceeded the manufacturer's daily dose recommendation. He explained by exceeding the manufacturer's recommended daily dose any side effects (including headache, back pain, sore throat, sinus pain) the medication could cause would be exacerbated (made worse). An interview with the NP on 07/01/21 at 12:13 PM revealed when she signed a pharmacy recommendation agreeing with the recommendation she expected nursing staff to update the order in the computer.	F 756	received from pharmacy, reviewed for acceptance or denial from physician/NP, reviewed for transcription of recommendation to the MAR as ordered. DON/Nursing designee will document the findings weekly and educate with any incomplete findings. This monitoring tool will be kept by the DON. Findings will be reported to the monthly QAPI meeting until such time substantial compliance has been achieved. The Director of Nursing is responsible for implementing the acceptable plan of correction. Completion Date 8/6/21.	
F 810 SS=D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to provide adaptive equipment during meals for 2 of 3 residents (Resident #63 and Resident #6) reviewed for adaptive equipment. Findings included: 1. Resident #63 was admitted to the facility	F 810	F810 This alleged deficiency was caused by a lack of education regarding dietary adaptive equipment. How will corrective action be accomplished for those residents found to have been affected by the deficient practice:	8/6/21

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F 810	Continued From page 13 10/05/16 with diagnoses including hemiplegia (paralysis of one side of the body) and stroke. Review of a Diet Order and Communication form dated 06/05/20 revealed Resident #63 was to receive a kennedy cup (a spill-proof cup with a handle) with meals. A quarterly Minimum Data Set (MDS) dated 05/28/21 revealed Resident #63 was moderately cognitively impaired, required supervision with eating, had impaired range of motion to an upper extremity, and received a mechanically altered therapeutic diet. The care plan for nutrition last updated 06/09/21 revealed Resident #63 was to be monitored for dysphagia (difficulty swallowing), receive his diet as ordered, and be monitored for malnutrition. On 06/28/21 at 12:42 PM Resident #63 was observed drinking a beverage in a regular cup in the main dining room. An observation of Resident #63's meal ticket at the same date and time revealed he was to receive a kennedy cup with meals. An interview with the Assistant Director of Nursing (ADON) on 06/28/21 at 01:00 PM revealed Resident #63 should have received a kennedy cup on his meal tray and confirmed he did not receive a kennedy cup on his meal tray. She stated the kitchen usually sent adaptive equipment on meal trays and she was unsure why Resident #63 did not receive a kennedy cup. An interview with Nurse Aide (NA) #1 on 06/28/21 at 01:08 PM revealed she served Resident #63 his lunch meal tray. NA #1 stated the kitchen	F 810	Resident #63 was provided a Kennedy Cup with his dinner meal on 6/28/21 per his care plan and has subsequently been provided one with all meals. Resident #6 was provided with a scoop plate for his dinner meal on 6/28/21 per his care plan and has also been receiving one since for all meals. How will corrective action be accomplished for those residents having the potential to be affected by the same deficient practice: The Therapy Manager and Dietary Manager reviewed orders for all dietary related adaptive equipment on 7/1/21 to ensure that orders for adaptive equipment were properly documented in Point Click Care (PCC). Those identified with discrepancies were corrected to ensure that the meal tickets match the orders, and the care plans and Kardex's are accurate. Additional Kennedy Cups or other adaptive equipment will be ordered as necessary to ensure they are available as ordered for each meal. What measures will be put into place or systematic changes made to ensure the deficient practice does not recur: All facility staff, including contracted staff, will be in- serviced on or before 8/6/21 by the Therapy Manager or Dietary Manager on the requirement that any and all adaptive equipment identified on the tray cards are provided to the resident. The Dietary Manager and all dietary	

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F 810	Continued From page 14 should have sent a kennedy cup out with Resident #63's meal tray and she did not notice he did not receive a kennedy cup on his meal tray. NA #1 stated when she served meals she looked at the meal ticket to confirm the right diet and right consistency and expected the kitchen to make sure adaptive equipment was provided. An interview with the Dietary Manager on 06/28/21 at 01:22 PM revealed adaptive equipment was supplied by the kitchen and the dietary aide sending the food out of the kitchen should have made sure the kennedy cup was on Resident #63's meal tray before the tray left the kitchen. An interview with Dietary Aide #1 on 06/28/21 at 01:25 PM revealed he reviewed meal trays for accuracy before they left the kitchen. He stated he knew Resident #63 was to receive a kennedy cup on his tray but nursing staff were not returning kennedy cups to the kitchen and he did not have one to put on Resident #63's meal tray. Dietary Aide #1 was unable to explain why he did not notify the Dietary Manager that no kennedy cup was available for Resident #63's meal tray. An interview with the Director of Nursing (DON) on 07/01/21 at 04:07 PM revealed adaptive equipment should be provided from the kitchen as stated on the meal ticket and if it was not staff serving the meal should obtain the adaptive equipment. 2. Resident #6 was admitted to the facility 06/17/20 with diagnoses including stroke and hemiplegia. Review of the quarterly MDS dated 06/17/21	F 810	department staff will be educated by the Director of Nursing or Infection Preventionist/ ADON on or before 8/6/21 on the requirement that adaptive equipment be placed on the resident's trays as ordered. Additional Kennedy Cups or other adaptive equipment will be ordered as necessary to ensure they are available as ordered for each meal. How the corrective actions will be monitored toEnsure the practice will not recur, i.e. what Quality assurance program will be put into place: To ensure ongoing compliance, audits of resident trays will be completed by designated facility staff twice daily for four (4) weeks, then daily for two (2) weeks and then weekly for two (2) weeks or until compliance has been determined. Any identified discrepancies will be corrected immediately with re-education provided as necessary. The results of these audits will be reported at the monthly QAPI meeting until such time substantial compliance has been achieved. The Director of Nursing is responsible for implementing the acceptable plan of correction. Completion Date 8/6/21.	

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F 810	Continued From page 15	F 810		

revealed Resident #6 was severely cognitively impaired, had impaired range of motion on one side of upper and lower extremities, and required set-up assistance with eating.

The care plan for activities of daily living (ADL) last updated 06/16/21 revealed Resident #6 had an ADL self-care performance deficit related to a stroke with right hemiparesis (weakness on the right side). Goals included maintaining his current level of function by feeding himself with set-up assistance and having ADL needs met with staff assistance.

On 06/28/21 at 12:34 PM Resident #6 was observed eating his meal from a lip plate (an adaptive dining plate that helps prevent food spills). An observation of Resident #6's meal ticket at the same date and time revealed Resident #6 was to have his meal served in a scoop plate (an adaptive plate that has a barrier to allow food to be pushed up against the side enabling food to stay on the spoon or fork).

An interview with the ADON on 06/28/21 at 01:00 PM revealed Resident #6 should have received his meal in a scoop plate and confirmed his meal was not served in a scoop plate. She stated the kitchen was responsible for sending out Resident #6's meal in the appropriate adaptive equipment and she was not sure why his meal was not served in a scoop plate.

An interview with NA #1 on 06/28/21 at 01:08 PM revealed she served Resident #6 his lunch meal. She stated Resident #6's meal was usually served in a lip plate and she was unsure if there was a difference between a lip plate and a scoop plate. NA #1 stated when she served meals she

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F 810	Continued From page 16 checked for the right diet and right consistency and expected the kitchen to serve meals in the appropriate plate. An interview with the Dietary Manager on 06/28/21 at 01:22 PM revealed a lip plate and a scoop were not the same and the cook should have plated Resident #6's meal in a scoop plate. An interview with Dietary Aide #1 on 06/28/21 at 01:25 PM revealed he was aware that Resident #6's meal was supposed to be in a scoop plate and he did not receive his meal in a scoop plate. He was unable to state why he did not notify the cook that Resident #6's meal was not in the correct plate before the tray left the kitchen. An interview with the Cook on 06/28/21 at 01:32 PM revealed she read Resident #6's tray ticket wrong and it was an oversight that he did not receive his meal in a scoop plate. An interview with the Occupational Therapist on 06/29/21 at 01:51 PM revealed the occupational therapy evaluation that recommended Resident #6 receive his food on a scoop plate occurred before she began working at the facility but if the tray ticket stated if a scoop plate was recommended food should be served on a scoop plate. An interview with the Director of Nursing (DON) on 07/01/21 at 04:07 PM revealed adaptive equipment should be provided from the kitchen as stated on the meal ticket and if it was not staff serving the meal should obtain the adaptive equipment.	F 810		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary	F 812		8/6/21

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F 812	Continued From page 17 CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to maintain a clean vent cover from an accumulation of dust on 1 of 2 ice machines. Findings included: An initial kitchen tour was conducted on 6/28/21 at 9:07 AM. An approximate ¼ inch accumulation of dust was observed on the outside of the ice machine vent cover. The ice machine was located directly across and approximately 10 feet away from the food service tray line. Interview with the Dietary Manager (DM) on 6/28/21 at 9:07 AM revealed the outside of the ice	F 812	F812 This deficiency was caused by staff members failure to follow established policies and procedures related to routine cleaning of ice machines. How will corrective action be accomplished for those residents found to have been affected by the deficient practice: The vent covering the ice machine was removed by the Maintenance Director and cleaned on 7/1/21. The other ice machine in the facility was also inspected by the	

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F 812	Continued From page 18 machine was wiped down daily, and the mechanical components were cleaned by the maintenance department. Observations in the kitchen on 6/29/21 at 2:18 PM, 6/30/21 at 11:06 AM and 7/1/21 at 9:22 AM revealed an approximate ¼ inch layer of dust visible on the outside of the ice machine vent cover. Interview with the Maintenance Director on 7/1/21 at 9:22 AM revealed he was responsible for cleaning the ice machine filter, but was not responsible for cleaning the outside of the ice machine. Follow up interview with the DM on 7/1/21 at 9:30 AM revealed the outside of the ice machine was cleaned and sanitized daily. The DM stated the amount of dust accumulation visible on the vent cover was not cleanly and it had not been cleaned. Review of the kitchen cleaning logs revealed detailed staff cleaning assignments which included deep cleaning the ice machine and wiping off the fan each week. Further review revealed the Manager in Training (MIT) signed completion of the ice machine cleaning on 6/29/21, that read "wipe off the fan". Interview with the (MIT) on 7/1/21 at 11:16 AM revealed she signed completion of the ice machine cleaning on 6/29/21. The MIT stated she only had access to the ice machine vent cover, and notified the Maintenance Director when she realized the cover was secured. The MIT stated the Maintenance Director was responsible for cleaning the ice machine fan and	F 812	Maintenance Director on 7/1/21 and found to be clean and without visible dust. How will corrective action be accomplished for those residents having the potential to be affected by the same deficient practice: Dietary staff will continue to wipe down the ice machine daily and the Maintenance Director will remove the vented cover and have it washed in the dish machine weekly to remove any potential dust accumulation. Completion of this cleaning will be documented using the existing kitchen cleaning logs. Dietary department staff and the Maintenance Director will be educated by the Dietary Manager or District Dietary Manager on or before 8/6/21 on the proper procedures for cleaning the ice machines, including the removal and washing of the vented cover weekly. What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur: To ensure that this deficient practice does not recur, dietary staff will continue to wipe down the ice machine daily and the Maintenance Director will remove the vented cover and have it washed in the dish machine weekly to remove any potential dust accumulation. Completion of this cleaning will be documented using the existing kitchen cleaning logs.	

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F 812	Continued From page 19 told her he would get to it.	F 812	How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: To ensure ongoing compliance, the Dietary Manager or designee will inspect the ice machine weekly for six (6) weeks, and monthly thereafter for two (2) months using an audit tool. Any non- compliance noted will be corrected immediately and staff re-educated as necessary. Findings will be reported at the monthly QAPI meeting until such time substantial compliance has been achieved. This plan of correction will be implemented by the facility Administrator. Completion Date 8/6/21.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		8/6/21

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F 880	Continued From page 20 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents	F 880		

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F 880	Continued From page 21 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 observations and staff and visitor interviews the facility failed to ensure 3 visitors wore N-95 masks, goggles, and gowns while interacting with 1 resident (Resident #279) on the quarantine unit who was not fully vaccinated for 1 of 2 residents reviewed for infection control. This failure occurred during a Covid-19 pandemic. Findings included: A review of a facility policy titled, "Tool Kit A Section I and II-Center Preparedness Infection Prevention Strategies and Guidance for COVID-19 revised 10/20/20" read in part: As of May 14, full Personal Protective Equipment (PPE) is recommended in the following areas: Admission units, Observation units, Dedicated areas where residents with suspected or confirmed COVID-19 are located, and Other units as directed by local/state health departments. The PPE recommended when caring for a resident on an admission unit, an observation unit, or a resident with suspected or confirmed COVID-19, regardless of the presence of	F 880	F880 This alleged deficiency was caused by the facility staff and visitor's failure to follow policies and procedures regarding utilizing personal protective equipment (PPE) to prevent the potential spread of Covid- 19. How will corrective action be accomplished for those residents found to have been affected by the deficient practice: The Private Sitters for resident #279 were immediately re- educated by the Infection Preventionist/ Assistant Director of Nursing on 6/28/21 on the requirement that that they utilize N95 respirators, gowns, eye protection and gloves while on the quarantine/ admission unit at all times and were provided with these items. Resident #279 was moved from the admission unit on 6/30/21 to the Life Engagement Unit (secured dementia unit) following a fourteen day quarantine. She has not required private duty sitters since that move. How will corrective action be accomplished for those residents having	

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F 880	Continued From page 22 symptoms includes: N95 Respirator Eye Protection Gloves Gowns An observation of the double doors to the quarantine unit on 06/28/21 at 03:12 PM revealed a sign posted stating "You Are in the Hot Zone-Full PPE Required Here". An observation of Private Sitter #1 on 06/28/21 at 03:12 PM on the quarantine unit revealed she was in the hall near the double doors at the entrance to the quarantine unit with Resident #279 attempting to redirect Resident #279 to stay on the quarantine unit. Private Sitter #1 was wearing a cloth face mask, a disposable gown, and eye glasses. An interview with Private Sitter #1 on 06/28/21 at 03:12 PM revealed her shift began at 2:00 PM. She stated she was screened at the entrance to the facility by having her temperature checked and completing a questionnaire. Private Sitter #1 stated she was wearing a cloth mask when she was screened and was not asked to replace her mask with a surgical mask. Private Sitter #1 stated she then walked through the facility and arrived at the quarantine unit. She explained there was no staff member at the nurse's station so she entered the quarantine unit and relieved the private sitter who worked the previous shift. Private Sitter #1 stated she found a disposable gown on the door caddy of isolation supplies on Resident #279's door and put the gown on. She explained there were no N-95 masks, goggles, face shields, or side shields available at the entrance to the quarantine unit or on the door	F 880	the potential to be affected by the same deficient practice: Facility staff in all departments, including contracted Dietary and Housekeeping/ Laundry, and Agency employees will be re-educated on or before 8/6/21 by the Director of Nursing or Infection Preventionist/ ADON on the requirements for utilizing personal protective equipment, as outlined in the most current Sava Toolkit on Center Preparedness: Infection Prevention Strategies and Guidance for Covid- 19. This training will include the requirement that all employees, health care professionals and visitors properly wear surgical facemasks while in the facility and that they utilize N95 respirators, gowns, eye protection and gloves while on the quarantine/ admission unit at all times. Newly hired staff members and agency staff will also be in-serviced on this requirement by the Director of Nursing, Infection Preventionist/ Assistant Director of Nursing or designee as part of the facility orientation. What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur: Facility staff in all departments, including contracted Dietary and Housekeeping/ Laundry, and Agency employees will be re-educated on or before 8/6/21 by the Director of Nursing or Infection Preventionist/ ADON on the requirements for utilizing personal protective equipment, as outlined in the most current Sava Toolkit on Center Preparedness: Infection Prevention Strategies and Guidance for	

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	345223	A. BUILDING _____ B. WING _____	C 07/01/2021

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F 880	Continued From page 23 caddy when she arrived to sit with Resident #279. Private Sitter #1 stated when she began sitting with Resident #279 approximately 2 weeks ago she was told by a nurse (whose name she could not recall) to stop at the nurse's station before entering the quarantine unit and she would be provided with a gown, N-95 mask, and goggles. She stated a couple of days later she was instructed by nursing staff to use whatever supplies were available on the door caddy of Resident #279's room and there were usually only gloves on the door caddy. An observation of the door caddy of PPE hanging on Resident #279's door on 06/28/21 at 3:49 PM revealed no N-95 masks, goggles, or face shields on the caddy. A sign posted on the door caddy of Resident #279's door was in place and stated Resident #279 was on "Special Airborne/Contact Precautions". The sign stated all visitors including family must not enter and were to report to the nursing station. Additional instructions stated all healthcare workers must wear an N-95 respirator (prior fit test required), gloves, gown, and protective eyewear. An interview with Nurse #2 on 06/28/21 at 03:31 PM revealed he was the nurse assigned to the quarantine unit for the 07:00 AM to 07:00 PM. Nurse #2 stated when staff or sitters entered the double doors at the entrance to the quarantine unit they were supposed to wear a gown, N-95 mask, and goggles or a face shield. He stated gloves were to be worn if resident care was provided, discarded after use, and hand hygiene was to be performed after gloves were discarded. He stated he knew Resident #279 had sitters that worked various shifts and when Private Sitter #1 began her shift at 2:00 PM he did not notice she	F 880	Covid- 19. This training will include the requirement that all employees, health care professionals and visitors properly wear surgical facemasks while in the facility and that they utilize N95 respirators, gowns, eye protection and gloves while on the quarantine/ admission unit at all times. Newly hired staff members and agency staff will also be in-serviced on this requirement by the Director of Nursing, Infection Preventionist/ Assistant Director of Nursing or designee as part of the facility orientation. The nurse assigned to the quarantine/ admission unit will be responsible for ensuring that adequate supplies of N95 masks, gowns, protective eyewear, and gloves are maintained at all times and stored in the door caddies of all occupied rooms on the unit. Visitors, including private sitters, are no longer permitted on the quarantine/ admission unit unless granted access under extenuating circumstances, such as for end of life visitation, and only if approved by the Director of Nursing or Infection Preventionist/ ADON. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: To ensure ongoing compliance, daily audits of staff and visitor’s practices of wearing appropriate PPE at all times while in the facility, including the use of N95 respirators, gowns, eye protection and gloves while on the quarantine/ admission unit, will be performed three (3) times per	

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F 880	Continued From page 24 was wearing a cloth mask and did not have a face shield or goggles. An interview with Unit Manager #1 on 06/28/21 at 03:51 PM revealed Resident #279's private sitters were screened using the same process as visitors. Unit Manager #1 stated all sitters for Resident #279 had been educated to stop at the nurses' station when they began their shift to get the required PPE including gowns, an N-95 mask, and goggles before entering the quarantine unit. She stated N-95 masks were kept in a drawer at the nurses' station and not on the door caddys of quarantine rooms to ensure they weren't disappearing from the facility. Unit Manager #1 stated gowns and goggles were also in a drawer at the nurses' station as well as on the door caddys on the quarantine unit. She explained gowns and gloves were restocked on door caddys daily by the van driver. Unit Manager #1 explained it was the responsibility of the nurse working on the quarantine unit to make sure Resident #279's private sitters were wearing the appropriate PPE when they were on the quarantine unit. An observation of Private Sitter #2 on 06/29/21 at 08:01 AM revealed she was sitting in a chair outside Resident #279's room with goggles on top of her head, an upside down N-95 mask resting below her neck, and a disposable gown draped loosely over her shoulders. An interview with Private Sitter #2 on 06/29/21 at 08:01 AM revealed she reported for her shift at 08:00 PM on 06/28/21 and she was scheduled to work until 08:00 AM on 06/29/21. She stated she rang the doorbell the evening of 06/28/21 and after 10 minutes a staff member let her in the	F 880	day for four (4) weeks and documented on an audit tool by the Director of Nursing, Infection Preventionist/ Assistant Director of Nursing, Unit Managers, Department Managers and/or designated nursing staff. Thereafter, audits will be completed daily for two (2) weeks, and then three (3) times per week for two (2) weeks. To ensure that the required PPE is available on the quarantine/ admission unit, audits of door caddies of occupied rooms on the unit will be performed two (2) times per day for four (4) weeks and documented on an audit tool by the Director of Nursing, Infection Preventionist/ Assistant Director of Nursing, Unit Managers, Department Managers and/or designated nursing staff. Thereafter, audits will be completed daily for two (2) weeks, and then three (3) times per week for two (2) weeks. Any deficiencies noted will be addressed immediately and corrective action taken as necessary, including disciplinary action. The results of these audits will be reviewed as part of the facility Quality Assurance & Process Improvement (QAPI) program monthly until such time substantial compliance has been achieved. The Director of Nursing is responsible for implementing the acceptable plan of correction. Completion Date 8/6/21.	

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F 880	Continued From page 25	F 880		

door and then walked off. Private Sitter #2 stated she completed her questionnaire and walked back to the quarantine unit to begin sitting with Resident #279. She stated no staff was present at the nurses' station so she entered the quarantine unit. Private Sitter #2 stated she was wearing a surgical mask when she entered the quarantine unit and wore the surgical mask until around 07:00 AM on 06/29/21 when a female staff member handed her goggles, an N-95 mask, and a gown and instructed her to put them on. Private Sitter #2 stated she had been the sitter for Resident #279 several times since her admission and had never been asked to wear goggles, a gown, or N-95 mask when on the quarantine unit. She stated she had not noticed the sign on the double doors leading to the quarantine unit or on Resident #279's door caddy. During the course of the interview with Private Sitter #2 Private Sitter #3 arrived to sit with Resident #279. Private Sitter #3 entered the quarantine unit through the double doors wearing a surgical mask and no goggles or gown.

An interview with Private Sitter #3 on 06/29/21 at 08:10 AM revealed she sat with Resident #279 during the day periodically since Resident #279's admission and had never been asked to wear an N-95 mask, a gown, or goggles. She stated she was usually screened in at the front door with a temperature check and questionnaire and then she walked back to Resident #279's room wearing a surgical mask. Private Sitter #3 stated she had not seen the sign on the double doors at the entrance to the quarantine unit or on Resident #279's door caddy and was not aware Resident #279 was on any type of isolation.

An interview with the Assistant Director of Nursing

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F 880	Continued From page 26	F 880		

(ADON) on 06/29/21 at 05:16 PM revealed private sitters were considered visitors and should be screened like all visitors. The ADON stated private sitters should be wearing an N-95 mask, a gown, and goggles when working on the quarantine unit. She stated there had been resistance from the private sitters for Resident #279 regarding wearing the correct PPE on the quarantine unit and she stated sitters had been educated on where to find PPE and what PPE to wear on the quarantine unit. The ADON stated the facility had no shortage of PPE including N-95 masks and if the PPE wasn't available on the door caddy or entrance to the quarantine unit sitters needed to ask a staff member for the PPE. She stated staff had received education to wear an N-95 mask, a gown, and goggles when working on the quarantine unit and she expected them to wear the appropriate PPE when working in any area of the faclity.

An interview with the Director of Nursing (DON) on 07/01/21 at 03:57 PM revealed some of the private sitters for Resident #279 were non-complaint with wearing appropriate PPE on the quarantine unit and had been educated they needed to wear an N-95 mask, a gown, and goggles when they were on the quarantine unit. She stated staff had been educated to wear an N-95 mask, a gown, and goggles when working on the quarantine unit and she expected staff to wear the appropriate PPE when working on the quarantine unit. The DON stated the facility had plenty of PPE and there was no reason staff members or sitters should not be wearing appropriate PPE when on the quarantine unit.

An interview with the Administrator on 07/01/21 at 05:13 PM revealed he expected staff and visitors

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F 880	Continued From page 27 to wear appropriate PPE and follow signage instructions when on the quarantine unit and throughout the facility.	F 880		