STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345113	A. BUILDING _____ B. WING _____	C 07/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW CREEK NURSING AND REHABILITATION CENTER	2401 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification survey was conducted on 07/26/2021 through 07/29/2021. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # B2DI11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 07/26/21 through 07/29/21. Event ID# B2DI11. 3 of the 28 complaint allegations were substantiated but did not result in a deficiency.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews the facility failed to ensure a resident could access the call bell to request staff assistance for 1 of 33 residents reviewed for call bells. (Resident #124). Findings included: Resident #124 was admitted to the facility on 9/14/11 with a diagnosis of hemiplegia and hemiparesis following cerebral infarction affecting left side.	F 558	558 Reasonable Accommodations Needs/Preferences Resident #124 Call bell was checked by the Unit Manager on 7/26/21 to ensure the call bell was within reach on resident's right side. Resident's care plan was updated on 8/17/21 by MDS nurse to ensure the call bell is on resident's right side. 100% of residents to include resident #124 were observed on 8/20/21 by the Director of Nursing and/or ADON to ensure the call bell is accessible and	9/7/21

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

Electronically Signed | 08/20/2021

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F 558	Continued From page 1 The quarterly Minimum Data Set dated 7/27/21 for Resident #124 revealed she had moderate cognitive impairment. She required extensive assistance with bed mobility and toileting. Transfers only occurred once or twice during the lookback period and supervision was need for eating. She had limited range of motion with impairment on one side. On 7/26/21 at 10:30 AM an observation and interview was conducted with Resident #124. Her call bell cord was observed wrapped around her bed rail on the left side and the call bell dangling toward the floor. She stated she was unable to use her left hand and she demonstrated she was unable to reach it with her right hand. Nurse #1 was observed going into the resident 's room on 7/26/21 at 10:33 AM. Nurse # 1 came out of the resident 's room at 10:36 AM. At 10:37 AM on 7/26/21 a second observation was made of Resident #124's call bell out of reach On 7/26/21 at 10:38 AM, Nursing Assistant (NA) #1 was in the resident 's room and stated Resident #124 could not reach her call bell in its current location. At 10:39 AM on 7/26/21 NA #1 was observed placing Resident #124 's call bell within her reach. An interview was conducted with NA #1 on 7/26/21 at 10:39 AM and he stated the resident was unable to use her call bell in its current location. He also stated when he provided care to any resident, the call bell was left in their reach.	F 558	within reach. Resident care plans will be updated for any resident identified with mobility issues and requires the call bell to be placed on a specific side of the resident. An in-service was initiated on 8/20/21 by the ADON with all nurses, CNAs, and therapy staff regarding ensuring calling lights are within reach and residents can access the call bell. The Administrator, DON, and/or ADON will audit 10% of residents weekly x 4 weeks then monthly x 1 month utilizing a call bell audit tool. This audit is to ensure call bells are within reach and accessible to the resident. The Administrator, DON and/or ADON will retrain the assigned nurse and/or nursing assistant during the audit for any identified areas of concern observed. The Administrator will review and initial the call bell audit tools weekly x 4 weeks then monthly x 1 month for compliance and to ensure all areas of concern have been addressed. The DON will present the findings of the call bell audit tools to the Executive Quality Assurance (QA) committee monthly for 2 months. The Executive QA Committee will meet monthly for 2 months and review the call bell audit tools to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring. Date of compliance 9/7/21	

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F 558	Continued From page 2 On 7/26/21 at 12:00 PM Nurse #1 stated while she was in the resident 's room, she did not notice the resident 's call bell was out of reach. She stated she should have made sure her call bell was in reach before she left the room. On 7/29/21 at 7:35 PM an interview was conducted with the Administrator and she stated the resident 's call bell should always be within reach.	F 558		
F 563 SS=F	Right to Receive/Deny Visitors CFR(s): 483.10(f)(4)(ii)-(v) §483.10(f)(4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. (ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time; (iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time; (iv) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and (v) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when	F 563		9/7/21

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F 563	Continued From page 3 such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation. This REQUIREMENT is not met as evidenced by: Based on observations, family interview, and staff interviews, the facility imposed a restricted visitation schedule that limited indoor visitations of family and friends for 1 of 1 resident reviewed for visitation. (Resident #285). This facility practice had the potential to affect all residents. Findings included: Willow Creek Nursing and Rehabilitation May 2021 Letter stated visitation was allowed under controlled settings. The letter encouraged visitations to occur outdoors, but indoor visitations might occur under certain conditions. The letter stated the facility reserved the right to limit the number of visitors to two per resident and to schedule visitations when staff can be available to supervise visitations and assist with the screening of visitors. The letter stated at this time, the facility was able to receive visitors, and visitors were advised they must call to schedule visitation in advance and that the current preferred visiting hours were Monday through Sunday 11:00 a.m. to 3:00 p.m. The letter stated to contact the Activities Director to review available visitation times. On 7/27/2021 at 12:34 p.m., an observation of the facility's main entrance door and the rehabilitation entrance door revealed a large white sign posted that stated no visitors were allowed in the building, and visitations were for end of life care and scheduled appointments.	F 563	F563 Rights/Deny Visitors Resident #285 family met with the Administrator on 7/28/21 regarding the current open visitation policy. A copy of the current visitation policy was mailed to resident #285 family by Administrator on 8/20/21. All resident representatives were mailed letters of the open visitation policy by the Administrator on 8/20/21. The open visitation policy was reviewed with all alert and oriented residents on 8/19/21 by the Social Workers and/or Activities. The visitation restriction sign was removed from the entrance door on 7/28/21 by the Assistant Administrator. An Inservice was completed with the Administrator, Director of Nursing, Activities Director and Activity Assistant on 8/16/21 by the RN Corporate Clinical Director regarding the current open visitation policy. An Inservice was initiated on 8/19/21 by the ADON with all other staff regarding the open visitation policy. The Social Workers will interview 5 visitors to include resident #285 visitors weekly x 4 weeks then monthly x 1 month utilizing a visitor interview audit tool. This audit is to ensure visitation was allowed and not restricted unless necessary per policy. The Social Work will provide training to staff as necessary for any identified areas of concern. The	

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F 563	Continued From page 4 Resident #285 was admitted on 7/21/2021. Her diagnoses included urinary tract infection with increased confusion. The Minimum Data Set (MDS) assessment dated 7/28/2021 was in progress but revealed Resident #285 was severely mentally impaired. On 7/27/2021 at 11:40 p.m. an interview with family member #1 of Resident #285 was conducted .She stated visitation appointments were to be scheduled from 11:00 p.m. to 3:00 p.m. She stated the family brought Resident #285 's husband to visit, and due to working, she was unable to visit during those hours. She stated family members were scheduled on different days and didn't understand why family members could not come on the same day. She stated the facility had allowed her to visit with Resident #285 after 3:00 p.m., but the staff acted like it was a bother. On 7/27/2021 at 2:54 p.m. in an interview with the Administrator, Assistant Administrator and the Director of Nursing (DON), the Administrator stated the facility was open to visitations seven days a week, but family members were asked to call ahead for arrangements to be made as needed. She stated usually two persons were allowed at a time for a visit. The Assistant Administrator stated the families were informed in the May 2021 letter the preferred time for visitation was 11:00 a.m. to 3:00 p.m. She stated the facility was in outbreak status from May to July 26, 2021 and the last COVID positive test was an employee on July 8, 2021. The DON stated she recalled setting up a visitation for Resident #285 family member the evening she was admitted and scheduled a visitation the next	F 563	Administrator or Director of Nursing will review and initial the visitor interview tools weekly x 4 weeks then monthly x 1 month for compliance and to ensure all areas of concern have been addressed. The DON will present the findings of the visitor interview tools to the Executive Quality Assurance (QA) committee monthly for 2 months. The Executive QA Committee will meet monthly for 2 months and review the visitor interview tools to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring. Date of Compliance 9/7/21	

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F 563	Continued From page 5 day for another family member to visit at lunch without checking the Activities Director's calendar. She stated the Activities Director had a calendar with time slots for visitation. The Administrator stated the facility used the calendar to prevent families from showing up all at once. On 7/27/2021 at 3:26 p.m., a Sunday to Saturday schedule board for visitations was observed in the Activities Director's office. Appointments were written on green sticky notes with the resident's name, room number, name of person visiting and type of visit: in the room, window visit or inside visit and posted under the day of the week scheduled. On 7/27/2021 at 3:37 p.m. in an interview with the Activities Director, she stated families were to call the facility before visiting the residents twenty four hours ahead of time. She further stated visitations were to occur between 11:00 a.m. to 3:00 p.m. While interviewing the Activities Director, the activities assistant was observed answering the phone and assisting a family member with scheduling a visitation for the upcoming Saturday. The activities assistant was observed telling a family member there was no time slot for 12:00 p.m. and asked if 2:00 p.m. would work. On 7/28/2021 at 10:40 a.m. in an interview with the activities assistant, she stated the reason a family member's visit was scheduled for Sunday at 2:00 p.m. was because there was already a visitation scheduled for the time requested on Saturday for another resident, not for the resident the family member was scheduling the appointment.	F 563		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice	F 582		9/7/21

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F 582	Continued From page 6 CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident	F 582		

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F 582	Continued From page 7 representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide an acknowledged Centers for Medicare and Medicaid Services (CMS) Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) (form 10055) and a Centers for Medicare and Medicaid Services (CMS) Notice of Medicare Non-Coverage (form 10123) prior to discharge from Medicare Part A skilled services for 2 of 3 residents reviewed for beneficiary protection notification review (Resident #43 and Resident #78). The findings included: 1. Resident #43 was admitted to the facility on 4/1/21 with diagnoses including edema. She was admitted to Medicare Part A skilled services on 4/1/21. Resident #43 ' s Minimum Data Set assessment dated 5/5/21, a significant change assessment revealed she was cognitively intact.	F 582	F582 Liability Notice A new liability notice was given to resident #43 on 8/11/21 by the social worker with the appropriate box checked and signature. The Administrator validated this on 8/16/21. The Social Worker will notify resident representative of #78 the process of notifications of medical non-coverage letters to include checking the box and signatures by 8/20/21. 100% audit of all Medicare “A” discharges for the past 30 days was completed by the Business Office Manager on 8/19/21. This audit was to ensure all Notifications of Medical Non-Coverage (NOMNC) was completed appropriately with the appropriate box checked and signature. All areas of concern were addressed by the Accounts Receivable to include issuing appropriate notification of non-coverage is provided to the	

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F 582	Continued From page 8 Resident #43's Medicare Part A skilled services ended on 5/6/21. She remained in the facility. Record review revealed Resident #43 did not sign the Notice of Medicare Non-Coverage (Form CMS 10123-NOMNC). The SNF ABN reviewed had Resident #43's name, the date services were to end, the estimated cost of the services and a statement that resident was made aware of non-coverage on 4/27/21. There was no signature on the form and there were no options checked for the decision made about continuing Medicare Part A services. An interview was conducted with Social Worker #1 on 7/28/21 at 2:48 PM. She stated the SNF ABN and NOMNC should have been signed by Resident #43. She further stated there should be an option checked for the decision made about continuing Medicare Part A services. The Social Worker stated she reviewed options with the resident but forgot to get her to sign the form. She indicated that there should have been documentation on the form about the discussion. An interview with the Administrator was conducted 7/28/21 at 4:15 PM who indicated the SNF-ABN form and the NOMNC form should have been completed accurately and signed by Resident #43. 2. Resident #78 was admitted to the facility on 5/12/21 with diagnoses that included dementia. She was admitted to Medicare Part A skilled services on 5/12/21. Resident #78 ' s Minimum Data Set assessment	F 582	resident/resident representative. On 8/19/21, an in-service was initiated by the Administrator with the Accounts Receivable and Social Workers in regards to Notifications of Medical Non-Coverage (NOMNC) with emphasis on providing appropriate notification related to non-coverage of Medicare “A” residents with the appropriate box checked and signature. In-service will be completed by 8/19/21. All newly hired Administrator, Accounts Receivable and/or Social Workers will be in-serviced during orientation in regards to Notifications of Medical Non-Coverage (NOMNC). 10% audit of all Medicare “A” discharges will be reviewed by the Business Office Manager weekly x 4 weeks then monthly x 1 month utilizing the NOMNC Audit Tool to ensure the appropriate notification of medical non-coverage was provided to the resident/resident representative with the appropriate box checked and signature. The Social Worker and/or Accounts Receivable staff will address all areas of concern identified during the audit. The Staff Facilitator will re-educate staff for any concerns identified. The Administrator will review and initial the NOMNC Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all areas of concern were addressed. The Administrator will forward the NOMNC Audit Tool to the Quality Assurance and Performance	

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F 582	Continued From page 9 dated 5/20/21, an admission assessment revealed she was moderately cognitively impaired. Resident #78's Medicare Part A skilled services ended on 6/16/21. Record review revealed neither Resident #78 nor her resident representative signed the Notice of Medicare Non-Coverage (Form CMS 10123-NOMNC). Record review revealed that neither Resident #78 nor her resident representative were given the SNF ABN. The SNF ABN reviewed had Resident #78's name and the date services were to end. There were no options checked for the decision made regarding continuing Medicare Part A skilled services. There were no other notes on the form. An interview was conducted with Social Worker #1 on 7/28/21 at 2:48 PM. She stated there should be an option checked for the decision made about continuing Medicare Part A services for Resident #78. She stated she spoke with Resident #78 's resident representative on 6/9/21 about Medicare Part A services ending and appeal rights. She indicated there should have been documentation on the form about the discussion. An interview with the Administrator was conducted 7/28/21 at 4:15 PM who indicated the SNF-ABN form should have been completed for Resident #78.	F 582	Improvement (QAPI) Committee monthly x 2 months. The QAPI Committee will meet monthly x 2 months and review the NOMNC Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring. Date of Compliance 9/7/21	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2)	F 644		9/7/21

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F 644	Continued From page 10 §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to refer a resident with a diagnosis of mental illness for a Preadmission Screening and Resident Review (PASARR) evaluation for 1 of 2 residents reviewed for PASARR (Resident #36). Findings included: Resident #36 was admitted to the facility on 4/25/19 with diagnoses that include mood disorder. A review of Resident #36's diagnoses revealed on 7/6/20 she was diagnosed with mood disorder due to a known physiological condition. On 12/1/20 she was diagnosed with a psychotic disorder with delusions due to a known	F 644	F 644 Coordination of PASARR and Assessments CFR(s): 483.209 (e)(1)(2) By 8-25-21 a preadmission screening and Resident Review (PASRR) will be completed for Resident # 36 by the Social Worker. A 100% audit of all current residents will be reviewed for new diagnosis of mental illness by MDS Department to be completed by 8/31/21. This audit is to ensure a Preadmission Screening and Resident Review (PASRR) was completed by the Social Worker for newly added mental illness diagnosis since resident's admission. All identified issues were corrected by the Social Worker with oversight by 9/7/21.	

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WILLOW CREEK NURSING AND REHABILITATION CENTER	2401 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 644	Continued From page 11 physiological condition. A physician progress note revealed Resident #36 was 12/1/20 was diagnosed with a psychotic disorder with delusions due to a known physiological condition. Resident #36's Minimum Data Set (MDS) assessment dated 5/7/21, a quarterly assessment revealed she was assessed as having moderate cognitive impairment. She was assessed as having no behaviors during the 7-day lookback period. A review of Resident #36's care plan last reviewed 5/19/21 revealed she was care planned for psychotropic use related to anxiety and mood disorder. The interventions included to administer psychotropic medications as ordered by the physician, monitor for adverse effects of antipsychotic use, and monitor for target behaviors and notify physician if behaviors worsen or increase in frequency. During an interview on 7/28/21 at 11:00 PM Social Worker #1 stated if there was a significant change Minimum Data Set assessment initiated a PASARR referral would be made. She stated she would not do a referral for a new psychiatric diagnosis. The Social Worker stated she was responsible for making the referral. She indicated that she would only make a referral if a significant change MDS assessment was done. During an interview on 7/28/21 at 3:14 PM Administrator indicated if a new psychiatric diagnosis required a new referral to NC MUST (North Carolina Medicaid Uniform Screening Tool) then Social Worker #1 should have followed the	F 644	On 8/20/21 the Social Worker (SW), Admissions Director, Minimum Date Set Nurse (MDS), and Director of Nursing (DON) were in-serviced by the Administrator on requirement for PASRR screening. 10% of Residents with a newly evident or possible serious mental disorder, intellectual disability, or related condition to include change in mental health status will be monitored by the MDS Nurses. This is to ensure that the facility submits and coordinates with the appropriate, State-designated authority, to ensure individuals with a mental disorder, intellectual disability, or a related condition to include change in mental health status receives care and service in the most integration setting appropriate to their needs weekly x 4 weeks and then monthly x 1 month. Any identified areas of concerns will be corrected during the audit by the Social Worker with oversight from the MDS Nurses to include completing a Preadmission Screening and Resident Review (PASRR). The Administrator will review and initial the PASRR audit tool weekly for 4 weeks then monthly for 1 month for completion and to ensure all areas of concern were addressed. The Administrator will forward the results of the PASRR Audit tool to the Executive QA Committee monthly x2 months. The Executive QA Committee will meet monthly x 2 months to review the PASRR Audit tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	

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F 644	Continued From page 12 correct referral process.	F 644	Completion Date 9/7/21	
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review, observations, staff interviews and a dialysis center staff interview, the facility failed to provide a nutritional supplement for 1 of 2 residents (Resident #110) reviewed for nutrition who experienced a weight loss, and failed to provide 1 of 2 residents (Resident #42) reviewed for nutrition a meal before leaving the facility for a dialysis appointment. Findings included:	F 692	F692 Nutrition/ Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) On 7/30/21, the supplement order for resident #110 was clarified and medication administration record was updated to reflect the supplement order by Unit Manager, Vicki Wells. Resident #42 received a breakfast meal prior to being transported to dialysis on 7/31/21 and was validated by the Administrator. On 8/23/2021, 100% of orders were	9/7/21

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F 692	Continued From page 13 1. Resident #110 was admitted on 7/6/2021. His diagnoses included Non-Alzheimer's dementia and urinary tract infection. The care plan dated 7/7/2021 revealed Resident #110's state of nourishment was less than body requirements characterized by weight loss, inadequate intake and decreased appetite related to leaving 25% or greater of food uneaten at most meals and receives supplement. Interventions included to provide diet as ordered, set up tray and encourage consumption of the meal, report to the unit supervisor when resident ate less than 75% of a meal, and refer to the dietician for evaluation and recommendations. The admission Minimal Data Set (MDS) dated 7/13/2021 revealed Resident #110 was severely mentally impaired and required limited assistance with eating. The MDS documented the admission weight at 123 pounds. Recorded weights in the medical record revealed Resident #110 had a 4.07% weight loss in the last thirteen days. The physician orders revealed Resident #110 was ordered a regular diet, and on 7/12/2021 Resource 2.0, a dietary supplement, sixty milliliters with the medication pass three times a day and documentation of the percentage consumed was ordered per the recommendations of the registered dietician. Dietary notes recorded Resident #110 was alert and responsive with no chewing or swallowing problems. Resident #110 was consuming 26-50% of all meals, and a nutritional supplement was	F 692	reviewed for the past 30 days to ensure all ordered supplements were transcribed on the medication administration record (MAR). The physician was notified, and orders clarified by the Dietary Manager for all identified areas of concern. All dialysis residents were observed from 8/21 thru 8/27/21 by Charge Nurse to ensure that all dialysis residents received a meal tray prior to going to dialysis. All identified areas of concern will be addressed by Charge Nurse during audit. An in-service was initiated on 8/20/21 by the DON, ADON, and/or Staff Development with all nurses regarding Transcribing supplement Orders on the MAR. All newly hired nurses will be in-serviced by the Staff Facilitator during orientation regarding Transcribing supplement orders on the MAR. An in-service was initiated with all nurses, CNAs, and dietary staff on 8/20/21 by ADON, DON, and/or SDC regarding ensuing dialysis residents receives meal trays prior to leaving for dialysis. All newly hired nurses, CNAs, and dietary staff will receive the Inservice in orientation. 10% of all new orders to include orders for supplements will be reviewed and compared to the MAR by the DON, ADON, and/or Unit Managers weekly x 4 weeks then monthly x 1 month utilizing the Supplement Audit Tool. This audit is to ensure that all orders to include supplements were transcribed accurately to the MAR and is being documented on the MAR after the supplement is provided. 10% of dialysis residents will be observed weekly x 4 weeks then monthly x 1 month	

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F 692	Continued From page 14 conducted on 7/13/2021. On 7/28/2021 at 11:37 a.m., a review of Resident #110's Medication Administration Record (MAR) revealed the nutritional supplement ordered on 7/12/2021 was not listed on the MAR. On 7/29/2021 at 2:46 p.m. in an interview with Nurse #2, she stated Resident #110 was not receiving the nutritional supplement. Nurse #2 reviewed the Medication Administration Record and stated it was not listed on the MAR. When she checked the physician 's orders for Resident #110, she found the order for the nutritional supplement. She stated the order was written by the Registered Dietician and was signed off by a nurse on 7/12/2021 but was not transcribed to the MAR. She stated the night shift nurses conducted a twenty four hour chart check for new orders and stated she would transcribe the order to the MAR. On 7/29/2021 at 3:16 p.m. in an interview with Director of Nursing, she stated the MAR was not electronic, and the nurses transcribed by handwriting the physician orders to the MAR. She stated the night shift nurses conducted chart checks for new orders. She stated the order for the nutritional supplement written on 7/12/2021 should had been transcribed to Resident #110's MAR on 7/12/2021. 2. Resident #42 was admitted to the facility on 12/3/2014, and her diagnoses included End Stage Renal Disease and Diabetes Mellitus. The annual Minimal Data Set (MDS) dated 2/19/2021 revealed Resident #42 was cognitively intact and required assistance setting up meals	F 692	prior to leaving for dialysis utilizing a Dialysis resident meal tray audit tool. This audit is to ensure dialysis residents receives a meal tray prior to leaving for dialysis. A snack bag or meal tray will be offered for any identified areas of concern. The DON will review and initial the Supplement and dialysis meal tray Audit Tools weekly x 4 weeks then monthly x 1 month for compliance and to ensure all areas of concern have been addressed. The DON will present the findings of the Supplement and dialysis meal tray Audit Tools to the Executive Quality Assurance (QA) committee monthly for 2 months. The Executive QA Committee will meet monthly for 2 months and review the Supplement and dialysis meal tray Audit Tools to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring. Completion date 9/7/21	

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F 692	Continued From page 15	F 692		

only. The MDS further revealed no significant weight loss or gain for Resident #42.

The care plan dated 5/11/2021 revealed Resident #42 required assistance with activities of daily living, and she was independent in eating but required set up assistance. The care plan further revealed she was at risk for fluid deficit and excess and interventions included providing diet as ordered, monitoring her weight and observing for signs of fluid volume deficits and swelling.

The physician orders revealed Resident #42 received hemodialysis on Tuesday, Thursday and Saturday.

A review of the medical record for Resident #42 revealed she was receiving a mechanical soft double protein meal at breakfast and consumed 50-100% of all her meals.

On 7/27/2021 at 3:30 p.m. in an interview with Resident #42, she stated she did not receive a breakfast meal or snack bag before transported to the dialysis center that morning. She stated she ate lunch after returning from dialysis.

On 7/27/2021 at 4:25 p.m. in an interview with the Dietary Manager, she stated Resident #42 was on the early breakfast tray list for dialysis on Tuesday, Thursday and Saturday. She stated the dietary cook fixed the early breakfast trays and the nursing staff picked the breakfast tray up after 5:30 a.m. She stated Resident #42 got a snack bag with her breakfast tray. She further stated when early breakfast trays were not picked up by the nursing staff, the breakfast tray was placed on the meal cart to go out to the hall with the regular breakfast trays. She stated she did not recall any

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F 692	Continued From page 16	F 692		

of the early breakfast trays not being picked up that morning.

On 7/28/2021 at 1:20 p.m. in an interview with Nurse #6, she stated when Resident #42's breakfast tray came out with the regular breakfast trays on days she was at dialysis, she gathered the milk and cereal off the breakfast tray and placed them in the staff kitchen. She stated Resident #42 usually returned from dialysis between 10:30 a.m. and 11:30 a.m., and she gave her the cereal to eat if she was hungry.

On 7/29/2021 at 6:20 a.m., no snack bag was observed with Resident #42 when she arrived at the dialysis center. She stated she was not given or offered a meal tray or anything to eat prior to leaving the facility for her dialysis appointment. When asked if she was hungry, Resident #42 answered, "Yes".

On 7/29/2021 at 6:42 a.m. in an interview with the dialysis nurse, she stated residents were not allowed to eat while on the dialysis machine due to aspiration precautions.

On 7/29/2021 at 6:50 a.m. in a phone interview with Nurse #7, she stated Resident #42 did not eat prior to leaving for the dialysis appointment and stated Resident #42 did not like to eat before going to dialysis. Nurse #7 stated she didn't know if the breakfast tray was delivered or if she had a snack bag prior to Resident #42 leaving for dialysis.

On 7/29/2021 at 6:55 a.m. in a phone interview with Nurse Aide #3, she stated Resident #42 usually ate two bowls of cereal before leaving for dialysis, but that morning on 7/29/2021 she left

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F 692	Continued From page 17	F 692		

the facility without eating breakfast or with a snack. She stated there was no one in the cafeteria when she went to the cafeteria. She further stated Resident #42's breakfast tray was delivered by the dietary staff after she had left for dialysis.

On 7/29/2021 at 7:44 a.m., Resident #42's breakfast meal tray was observed on the overbed table. The breakfast meal tray consisted of sausage, eggs and a box of cereal. There was no milk carton observed on the breakfast tray.

On 7/29/2021 at 7:50 a.m. in an interview with the dietary cook, she stated she reported to work at 5:35 a.m., and a breakfast meal tray was prepared for Resident #42. She stated no one came to the kitchen requesting milk, a snack, or the meal tray for Resident #42. She stated when no one came for the meal tray, the dietary assistant carried the breakfast meal tray to Resident #42's room, but she had already left for her dialysis appointment.

On 7/29/2021 at 8:01 a.m. Resident #42's name was observed on the daily schedule dated 7/29/2021 for residents leaving the facility. The departure time for Resident #42 was listed as 6:00 a.m.

On 7/29/2021 at 8:37 a.m., the Dietary Manager stated she had sent a snack bag for Resident #42 to the dialysis center.

On 7/29/2021 at 3:16 p.m. in an interview with the Director of Nursing, she stated the dietary staff were responsible to know what residents were scheduled for early dialysis appointments to prepare the resident's food prior to their departure

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F 692	Continued From page 18 to the dialysis center. She stated the nurse aides were responsible for picking up the breakfast tray for residents to eat prior to dialysis appointments. She stated the nursing staff should have offered or provided the meal tray or something to Resident #42 prior to transporting to the dialysis appointment on 7/29/2021. She further stated a snack bag was delivered to the dialysis center for Resident #42 so she would have something.	F 692		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F 880		9/7/21

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F 880	Continued From page 19 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 880		

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F 880	Continued From page 20 Based on the record review, observations, resident interviews, staff interviews and a physician interview, the facility failed to implement the facility 's infection control measures for the quarantine unit when 1) Nurse # 2 was observed entering a resident 's room wearing only an N-95 mask for 1 of 21 residents on the 1000 hall of the quarantine unit, a Social Worker was observed entering a resident 's room wearing only an N-95 and an isolation gown on the 1100 hall of the quarantine unit, and the Nurse Aide #2, Social Worker and Physician were observed exiting 3 of 21 residents rooms on the 1100 hall quarantine unit wearing the isolation gowns and removing the isolation in the hallway of the quarantine unit, 2) change a peripherally inserted central catheter (PICC) dressing weekly as ordered by the physician for 1 of 1 resident (Resident# 111) reviewed, and 3) maintain social distancing in the smoking area for 2 of 2 residents reviewed. (Residents # 69, #76) This occurred during the COVID pandemic. Findings included: The facility's policy, "Guidelines on Latest Approach to PPE Use During COVID Pandemic" dated 6/21/2021, stated N-95 mask, eye protection and gowns were required PPE on the quarantine unit, and gowns should be changed between each patient and not reused or used in an extended manner. The policy further stated gowns should be doffed prior to exiting the patient's room and disposed. The facility' policy, "Guidelines for Admissions and Readmissions during COVID-19 Pandemic" dated 5/10/2021, stated New admissions or readmissions to the designated admission and	F 880	F880 Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) Nurse #2, nurse aide #2, and the social worker will be in-serviced by 9/7/21 by DON regarding Donning and Doffing full PPE to include gown, gloves, mask, and eye protection and proper disposal of PPE when in a quarantine room. The Physician is no longer employed at the facility. Resident #111 PICC line dressing was changed on 7/29/21 by nurse #2. Resident #69 and #76 who are alert and oriented, will be educated on the CDC guidance for social distancing by the Administrator by 9/7/21. The DON, ADON, Unit Supervisors, and/or MDS Nurses will complete 100% return demonstration with all staff to include Nurse #2, nurse aide #2, and the social worker by 9/7/21 regarding Donning and Doffing full PPE and proper disposal prior to leaving a Quarantine room. This observation is to ensure that all staff successfully demonstrate Donning full PPE to include gown, eye protection, gloves, and mask prior to entering a quarantine room and Doffing and disposing of the PPE prior to exiting the room. Staff will be immediately retrained by the DON, ADON, Unit Supervisors and/or MDS Nurses during the audit for any identified areas of concern. The DON, ADON, Unit Supervisors and/or MDS Nurses will observe 100% of residents with PICC lines to include resident #111 by 9/7/21 to ensure the dressing has been changed per physician’s order. The site will be assessed, and the dressing changed for	

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F 880	Continued From page 21 readmission quarantine area must be placed on contact and droplet precautions with full PPE use by the staff. On 7/26/2021 at 8:30 a.m. upon entering the facility, the Administrator stated N-95 masks, gown, gloves and eye protective wear were the required personal protective equipment (PPE) on the quarantine unit. She stated new admissions were admitted to the 1000 and 1100 halls, the quarantine unit. On 7/26/2021 at 9:25 a.m. on a tour of the quarantine unit, contact and droplet precaution signage or enhanced precaution signage and "Use of PPE when Caring for patients confirmed or suspected of COVID" were observed on all the resident' doors in the quarantine unit. PPE was observed hanging on resident's doors along the hallways on the quarantine unit. On 7/26/2021 at 9:35 a.m., PPE: goggles, gowns, N-95 masks and gloves were observed in a closed upright metal cart located on a wall adjoining the 1000 and 1100 hallways of the quarantine unit. 1. On 7/26/2021 at 12:52 p.m. Nurse #2 was observed entering room 1008 wearing an N-95 mask but no gloves, gown, or eye protection standing beside the resident talking and touching items on his overbed table. Contact precautions and droplet precautions signage was observed on the door of room 1008. Before exiting the room, Nurse #2 entered the bathroom and performed hand washing. On 7/26/2021 at 9:36 a.m., Nurse #3 stated staff on the quarantine unit were required to wear N-95	F 880	any identified areas of concern. 100% of all independent smokers to include resident #69 and resident #76 will be educated by 9/7/21 by the Administrator, Activities and/or Social Workers regarding the CDC recommendations for social distancing during a pandemic. A sign will be placed at the exit door of the smoking area and 10-12 ft markers will be placed in the smoking area by 9/7/21 by the Maintenance Department as a reminder for residents to social distance. An Inservice will be initiated with all staff to include nurse #2, nurse aide #2, and the social worker by 9/7/21 by the DON, ADON, Unit Supervisors and/or MDS regarding Donning and Doffing full PPE to include gown, gloves, mask, and eye protection and proper disposal when in a quarantine room; required social distancing in the smoking area. All nurses to include Nurse #2, #4, and #5 will be in serviced on by 97/21 by the DON, ADON, Unit Supervisors and/or MDS regarding following physician orders for PICC line dressing changes. All newly hired staff will receive the in services during orientation by the Staff Facilitator. The ADON, Unit Supervisors and/or MDS will observe 10% of all staff to include Nurse #2, nurse aide #2, and the social worker Don and Doff PPE while in the Quarantine unit. The observations will be completed weekly x 4 weeks then monthly x 1 month utilizing a Donning and Doffing Audit Tool. This observation is to ensure that all staff Donn full PPE to include gown, gloves, mask, and eye protection prior to entering a quarantine room and	

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	345113	A. BUILDING _____ B. WING _____	C 07/29/2021

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F 880	Continued From page 22 masks, eyewear, gowns and gloves for resident care. On 7/26/2021 at 9:31 a.m. Nurse Aide #2 was observed exiting room 1102 wearing an N-95, goggles and an isolation gown. She removed the isolation in the hallway and disposed of the isolation gown in the large trash barrel located in the hallway outside room 1102. The contact precautions signage on the door of room 1102 instructed Nurse #2 to remove the gown before exiting the room. Nurse Aide #2 was observed using the hand sanitizer in the hallway after discarding the gown. On 7/26/2021 at 9:45 a.m. in an interview, Nurse Aide #2 stated N-95 mask, gown, gloves and face shield were required before entering a resident 's room on the quarantine unit. She stated the PPE was removed inside the room before exiting. She stated there wasn't a reason why she removed the gown outside in the hallway, she was just working. She stated she had received training on donning and doffing PPE. On 7/26/2021 at 12:57 p.m. a physician was observed exiting room 1106 on the quarantine unit and walking down the hallway wearing a N-95 mask, goggles and the isolation gown. On 7/26/2021 at 12:57 p.m. in an interview with the Physician, the Physician stated the resident in room 1106 was not on isolation, and only residents where PPE was hanging from the door were on isolation in the quarantine unit. When the contact and droplet precaution signage on the door of room 1106 was brought to the Physs attention, she stated she needed to remove her gown and removed the isolation gown in the	F 880	Doff and proper dispose of the PPE prior to leaving the room. Staff will be immediately retrained by the ADON, Unit Supervisors and/or MDS during the audit for any identified areas of concern. 10% of residents with PICC lines will be observed by the ADON, Unit Supervisors and/or MDS weekly x 4 weeks then month x 1 month utilizing the PICC line dressing change audit tool. This audit is to ensure that the PICC line dressing has been changed per physician ‘s order. The site will be assessed, the dressing changed, and the nurse will be retrained for any identified areas of concern during the audit. The Activities Department, Social Workers and/or Maintenance Department will observe the smoking area weekly x 4 weeks then monthly x 1 month utilizing the smoking area audit tool. This audit is to ensure that residents are following social distancing while in the smoking area. The Activities Department, Social Workers and/or Maintenance Department will reeducate the resident for any identified areas of concern. The Director of Nursing (DON) or Administrator will review and initial the Donning and Doffing Audit Tools, PICC line dressing change audit tools, and smoking area audit tools weekly x 4 weeks then monthly for 1 month to ensure all identified areas of concern have been addressed. The Director of Nursing or Administrator will forward the results of the Donning and Doffing Audit Tools, PICC line dressing change audit tools, and smoking area audit tools to the Executive QA Committee monthly x 2 months. The Executive QA	

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F 880	Continued From page 23 hallway and placed the isolation gown in the large trash barrel in the hallway. On 7/26/2021 at 12:58 p.m., the Social Worker was observed entering room 1105 on the quarantine unit wearing a N-95 mask and an isolation gown. She was not observed wearing eye protective wear. Contact and droplet precaution signage was observed on room 1105. On 7/26/2021 at 1:00 p.m., the Social Worker was observed exiting room 1105 on the quarantine unit wearing the isolation gown, N-95 mask, and no protective eye wear. She walked up the hallway to the lobby area. On 7/26/2021 at 1:00 p.m. in an interview with the Social Worker, she stated she should have taken the gown off when she came out of the room. She stated she had received PPE training and removed the isolation gown in the lobby area and walked down the hallway, placed the isolation gown in the large trash barrel located in the hallway and sanitized her hands. She returned to the lobby area and stated PPE was located on the doors and was applied before entering the rooms and was removed before exiting the room. She further stated trash cans were in the rooms to dispose PPE before exiting the resident's rooms in the quarantine unit. On 7/29/2021 at 3:16 p.m. in an interview with the Director of Nursing, she stated N-95 mask and goggles were required on the quarantine unit, and gown and gloves were additional PPE required in the resident's room. She stated the gown and gloves were to be removed prior to leaving the resident's room, and the N-95 mask was changed if treatments were performed. She stated the	F 880	committee will meet monthly for 2 months to review the Tools for trends and/ or issues and to determine the continued need and frequency of monitoring. Completion Date 9//7/21	

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facility had conducted an in-service with the staff on the use of PPE and donning and doffing PPE.

On 7/29/2021 at 4:14 p.m. in an interview with the Assistant Administrator, she stated N-95 and goggles were required in the quarantine unit, and gowns and gloves were applied before entering the resident' room in the quarantine unit and were removed before leaving the resident's room. She further stated the staff had received training on use of PPE.

2. Resident #111 was admitted to the facility on 7/6/2021.

A review of the July 2021 Intravenous Administration Record revealed the PICC line dressing was to be changed every seven days with a transparent and gauze dressing. The Intravenous Administration Record was marked indicating the PICC line dressing was to be changed on the 19th and 26th of July, and there was no documentation of nursing initials indicating the treatment was performed. Documentation on the intravenous administration record revealed nurses had monitored the PICC line site every four hours, administered intravenous medication daily and changed the injection caps on the PICC line every seven days on the 19th and 26th of July.

On 7/28/2021 at 8:27 a.m., the night shift Nurse #4 was observed administering intravenous antibiotics through the PICC line to Resident #111. The PICC line dressing was observed dated 7/16/2021. Nurse #4 stated the PICC line dressing was changed every seven days by the nurse assigned the hall.

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On 7/29/2021 at 9:53 a.m. in an interview with the night shift Nurse #5, she stated the PICC line dressing was changed on the day shift per the medication administration record and was not sure if the PICC line dressing had been changed. She stated when the PICC line dressing was changed, the nurse would date the dressing and sign the medication administration record.

On 7/29/2021 at 10:00 a.m., a transparent PICC line dressing dated 7/16/2021 was observed on Resident #111's upper arm. The transparent dressing was attached to the upper arm except for the lower left corner of the transparent PICC dressing. There was no redness or swelling noted a the PICC site.

On 7/29/2021 at 10:00 a.m., Resident #111 stated the PICC line dressing had not been changed since 7/16/2021. He stated the PICC line dressing was applied on 7/6/2021 and changed on 7/16/2021.

On 7/29/2021 at 10:10 a.m. in an interview with day shift Nurse #2 , she stated the PICC line dressing was to be changed weekly by the night shift. Nurse #2 reviewed Resident #111's medication administration record and stated, "based on the MAR the dressing has not been changed." She further stated the PICC line dressing needed to be sealed for infection control issues. When Nurse #2 was informed the PICC line dressing was dated 7/16/2021, she stated she would change the PICC line dressing today.

On 7/29/2021 at 3:16 p.m. in an interview with the Director of Nursing (DON), she stated the PICC line dressing should be changed every seven days as ordered. She further stated the

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medication administration record prompted the nurses when to change the PICC line dressing, and nurses dated the dressing and initialed the MAR to document when the task was performed.

3. A review of the Centers for Disease Control (CDC) recommendations, updated March 29,2021, revealed guidance under Implement Physical Distancing measures: Maintaining physical distance between people (at least 6 feet) is an important strategy to prevent COVID transmission.

On 7/29/2021 at 12:20 PM, Resident #69 and Resident #76 were observed sitting in wheelchairs in the designated smoking area in the facility courtyard. Resident #69 was smoking, and Resident #76, who was not smoking, was three feet away conversing with Resident #69.

At 3:25 PM on 7/29/2021, three residents were observed in the smoking area of the facility courtyard. Two of the residents were smoking and sitting in wheelchairs with one foot between each wheelchair. The third resident was sitting at a picnic table alone, smoking.

On 7/29/2021 at 4:00 PM, the Administrator was interviewed and stated the facility followed the CDC recommendations of residents being socially distanced. The Administrator stated staff encouraged residents to socially distance when smoking.

At 6:00 PM on 7/29/2021, six residents were observed in the smoking area of the facility

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F 880	Continued From page 27 courtyard. Two residents were socially distanced and smoking. Four residents were in wheelchairs one foot apart. All six residents were smoking. At 6:05 PM on 7/29/2021, the Facility Nurse Consultant was asked if there was a policy for smokers being socially distanced when in the smoking area. The Consultant stated there was not a policy, but staff encouraged smokers to socially distance, according to CDC recommendations.	F 880		