STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. BUILDING _____ B. WING _____	C 08/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SATURN NURSING AND REHABILITATION CENTER	1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262

(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 08/01/21 through 08/13/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #B5B911.	E 000		
F 000	INITIAL COMMENTS A Recertification and Complaint survey were conducted from 08/01/21 through 08/13/21. Immediate Jeopardy was identified at: CFR 483.25 at tag F689 at a scope and severity (J). The tags F689 and F697 constituted Substandard Quality of Care. Immediate Jeopardy began on 05/17/21 and was removed on 08/10/21. An extended survey was conducted. 1 of the 60 complaint allegations was substantiated but did not result in a deficiency. 39 of the 60 complaint allegations were substantiated resulting in deficiencies.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or	F 578		9/20/21

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

Electronically Signed | 09/06/2021

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F 578	Continued From page 1 inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to maintain accurate advanced directives throughout the medical record for 1 of 1 resident reviewed for advanced directives (Resident #65). Findings included:	F 578	Saturn Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and purpose of this Plan of Correction to the extent the summary of findings is factually correct in order to maintain compliance with applicable rules and provisions of quality of care of	

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F 578	Continued From page 2 Resident #65 was admitted to the facility on 07/27/18 with multiple diagnoses that included Alzheimer's disease and dementia without behavioral disturbance. Resident #65's paper medical record revealed a Medical Orders for Scope of Treatment (MOST) form dated 06/19/20 that indicated her preference for a Do Not Resuscitate (DNR) status in the event she had no pulse and was not breathing. The form was signed by Resident #65's Responsible Party. The quarterly Minimum Data Set (MDS) dated 05/24/21 assessed Resident #65 with severe impairment in cognition. Resident #65's advanced directive care plan, initiated on 07/06/21, revealed her wishes would be honored relative to DNR code status. Resident #65's Electronic Medical Record (EMR), reviewed on 08/02/21 at 11:07 AM, revealed the following: On the profile page, Resident #65's code status was listed as "Cardiopulmonary Resuscitation "CPR" (manual application of chest compressions and ventilation done when someone's breathing or heartbeat has stopped). Under Physicians Orders, there was a current order dated 07/06/21 that indicated Resident #65 had a code status of DNR. During an interview on 08/03/21 at 9:05 AM, Nurse #4 explained she referred to the current physician's orders in the resident's EMR when determining code status. Nurse #4 reviewed Resident #65's EMR and confirmed the code	F 578	residents. The Plan of Correction is submitted as written allegation of compliance. Preparation and submission of this Plan of Correction is in response to the CMS 2567 from the survey conducted on August 1-13, 2021. Saturn Nursing and Rehabilitation Center response to the Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Furthermore, Saturn Nursing and Rehabilitation Center reserves the right to refute any deficiency on the Statement of Deficiencies through Informal Dispute Resolution, formal appeal and/or other administrative or legal procedures 1. Facility failed to maintain accurate advanced directives throughout the medical record for Resident #65. Advance Directive was corrected on 8/3/2021. 2. An audit will be conducted on all current residents to ensure accuracy of code status throughout the medical record by the Director of Nursing, Assistant Director of Nursing, Unit Coordinators, and the Social Worker. This audit will be completed by 9/20/2021. 3. Regional Nursing Consultant to educate Director of Nursing, Assistant Director of Nursing, Unit Managers, and Social Worker on ensuring residents have	

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F 578	Continued From page 3 status of CPR on her profile page conflicted with the physician's order dated 07/06/21 which indicated she was a DNR. Nurse #4 added the code status on the profile page and physician's order should match. During an interview on 08/03/21 at 10:02 AM, the Director of Nursing (DON) stated nursing staff were responsible for obtaining a resident's code status and entering the physician's order in the resident's EMR. The DON reviewed Resident #65's EMR and confirmed the code status of CPR on her profile page conflicted with the physician's order dated 07/06/21 which indicated she was a DNR. The DON stated both should match and the conflicting information related to code status could be detrimental in the event of an emergency. She added Resident #65's EMR should be updated to accurately reflect her wishes. During an interview on 08/03/21 at 10:35 AM, the Administrator stated Resident #65's code status listed in her paper medical record, physician's order and EMR should all match so in the event of an emergency, there would be no confusion and her wishes would be honored.	F 578	the accurate code status upon admission throughout the medical records. The code status it to be reviewed at least quarterly, at a significant change in condition, and annual. This education will be added to orientation packet for new hires. Education completed by 9/20/2021. Director of Nursing, Assistant Director of Nursing, Unit Managers, and/or designee will audit 15 residents per week x 4 weeks, 10 residents per week x 4 weeks, and 5 residents per week x 4 weeks to ensure accuracy of code status throughout medical record. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to Quality Assurance and Performance Improvement (QAPI) by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. Date of Compliance 9/20/2021 5. Person Responsible: Director of Nursing	
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	F 584		9/20/21

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F 584	Continued From page 4 but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature 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, record review, and	F 584	1. The facility failed maintain the walls in	

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F 584	Continued From page 5 interviews the facility failed: maintain the walls in resident rooms in good repair for resident rooms on 3 of 3 halls (rooms 180, 117, and 262); keep a toilet seat in good repair for 1 of 2 resident bathrooms (bathroom of room 263); repair broken chairs in 1 of 1 dining room; ensure a baseboard was in place for 1 of 1 dining room wall; ensure a baseboard was in good repair for 1 of 1 resident room (room 180); ensure drawers in a resident's built in chest was in good repair for 1 of 1 resident room (room 117); ensure sanitary ceiling vents for 1 of 1 dining room; ensure a working overhead light was in place for 1 of 2 resident bathrooms (room 176). The findings included: 1. An observation of room 180 on 08/02/21 at 08:40 AM revealed an exposed circular area of sheetrock to the wall beside A bed and multiple linear scratches with missing paint to the wall behind A bed. The corner of the wall near B bed's closet had exposed metal with peeling paint extending up to approximately ¾ of the corner. The corner near the bathroom door had an area of detached partially unpainted metal that extended approximately ½ inch from the wall. A broken baseboard was observed to the wall beside the bathroom door. An observation or room 180 on 08/03/21 at 09:41 AM revealed the same conditions. 2. An observation of room 117 on 08/02/21 at 02:12 PM revealed an area of exposed sheetrock to the wall beside the entry door. The top drawer of the left side of the built in chest was missing. The bottom drawer of the chest built into the wall had broken wood to the front of the drawer. An observation of room 117 on 08/03/21 at 09:05 AM	F 584	resident rooms in good repair for resident rooms on 3 of 3 halls (rooms 180, 117, and 262); keep a toilet seat in good repair for 1 of 2 resident bathrooms (bathroom of room 263); repair broken chairs in 1 of 1 dining room; ensure a baseboard was in place for 1 of 1dining room wall; ensure a baseboard was in good repair for 1 of 1 resident room (room 180); ensure drawers in a resident's built in chest was in good repair for 1 of 1 resident room (room117); ensure sanitary ceiling vents for 1 of 1 dining room; ensure a working overhead light was in place for 1 of 2 resident bathrooms (room176). The walls in rooms 180, 117, and 262 will be repaired by 9/20/2021. Toilet seat for bathroom 263 will be replaced by 9/20/21. Broken chairs were removed from dining room on 8/3/2021. Baseboard in the dining room and room 180 will be repaired by 9/20/2021. Chest in room 117 will be repaired by 9/20/2021. Ceiling vents in dining room were cleaned on 8/3/2021. Overhead light in bathroom of 176 will be repaired by 9/20/2021. 2. Executive Director, Maintenance Director and Housekeeping Manager to audit facility to ensure that furniture, toilet seats, walls, baseboards, and overhead bathroom lights were in good repair. Facility ceiling vents to be audited to ensure cleanliness. This audit to be completed by 9/20/2021. 3. Executive Director to educate Maintenance Director and Housekeeping	

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F 584	Continued From page 6 revealed the same conditions. An observation of room 117 on 08/04/21 at 11:48 AM revealed the same conditions. 3. An observation of the main dining room on 08/03/21 at 11:00 AM revealed 2 dining room chairs had both chair arms broken. The baseboard on the wall of the main dining room near the left kitchen door was observed to be missing. Three ceiling vents in the main dining room were observed to be covered with a black substance and a black substance was noted to be on the ceiling around the vents. 4. An observation of the bathroom of room 176 on 08/01/21 at 01:12 PM revealed a floor lamp sitting between the toilet and sink with the cord running under the sink and plugged into the wall. The overhead light in the bathroom was not working. A hole was noted to the bathroom wall across from the toilet that was the approximate length of the door handle. An observation of the bathroom of room 176 on 08/04/21 at 10:20 AM revealed the same conditions. 5. An observation of room 262 on 08/01/21 at 11:32 AM revealed peeling paint to the walls behind both beds. An observation of room 262 on 08/02/21 at 10:07 AM revealed the same conditions. 6. An observation of the bathroom of room 263 on 08/02/21 at 10:11 AM revealed the toilet seat was loose. An observation of the bathroom of room 263 on 08/04/21 at 10:20 AM revealed the same condition. An interview with the Maintenance Director on 08/04/21 at 04:24 PM revealed he recently	F 584	Manager on ensuring that the facility furniture, toilet seats, walls, baseboards, and overhead bathroom lights are in good repair, as well as maintaining clean ceiling vents. Education to be completed by 9/20/2021. Maintenance Director and/or Housekeeping Manager will conduct weekly audits x 12 weeks to ensure that dining room furniture, baseboards, and ceiling vents are clean and in good repair. Executive Director or designee will conduct audits of resident rooms to ensure furniture, toilet seats, walls, baseboards, and overhead bathroom lights are in good repair. Audit to include 15 resident rooms x 4 weeks, 10 resident rooms x 4 weeks, and 5 resident rooms x 4 weeks. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Executive Director monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Responsible Person: Executive Director Date of compliance is 9/20/2021	

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F 584	Continued From page 7	F 584		

resigned his full-time position but agreed to work part-time until a full-time Maintenance Director could be hired. He explained before he stopped working full-time he placed a notebook at each nursing station where staff could document work orders but now there was a binder in a central location where staff could document work orders and he would prioritize the work orders. The Maintenance Director stated toilets, beds, call lights, and wheelchair repairs were his top priority.

A follow-up interview with the Maintenance Director on 08/05/21 at 04:16 PM revealed he was responsible for changing light bulbs, fixing baseboards, fixing furniture in resident rooms, fixing toilet seats, and painting and patching repairs. He explained he did an environmental round weekly on 6-8 resident rooms and that ensured he was able to round on all rooms quarterly. The Maintenance Director stated he had a running list of items that needed to be painted or patched and someone was hired to work on but he resigned before the list was completed.

A tour of the facility was completed with the Maintenance Director on 08/05/21 at 04:45 PM. The Maintenance Director stated he was not aware of the missing baseboard in the main dining room, was not aware of the broken chairs in the main dining, and he thought Housekeeping had a cleaning regimen for the ceiling vents. He stated he was aware of the peeling paint in room 262 and thought it was on the paint and patch list that did not get completed. The Maintenance Director stated he was not aware of the loose toilet seat in room 263 and he would be able to fix it today. He stated he was not aware of the

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F 584	Continued From page 8	F 584		

exposed sheetrock, scrapes to the wall, missing baseboard, or metal corners being exposed in room 180. The Maintenance Director stated he was not aware of the missing drawer on the built-in chest and the broken wood to the last drawer on the chest in room 117. He stated the unpainted area on the wall in room 117 was on the paint and patch list that did not get completed by the former maintenance staff member. The Maintenance Director stated he was not aware of the overhead bathroom light not working or the hole in the wall behind the bathroom door in room 176 and he would replace the light bulb and add a plastic wall plate.

The maintenance work order log was reviewed 08/05/21 at 05:00 PM and there was a notation on the 05/03/21-05/04/21 to patch the corner of room 180. On the work order log for 05/03/21-05/04/21 a missing drawer was noted for room 117.

An interview with the Administrator on 08/05/21 at 06:00 PM revealed when the Maintenance Director was not present staff notified her of any maintenance issues. She explained if it was something she could handle she would address the issue. The Administrator stated the part-time maintenance staff member did not notify her of any maintenance concerns and she was not aware of the environmental concerns brought to the Maintenance Director's attention during the tour. She further stated the former part-time maintenance staff member would repair the paint in visible areas and would take his paint trolley into resident rooms, close the door, and give the illusion he was painting but did not complete the work.

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F 584	Continued From page 9 An interview with the Housekeeping Supervisor on 08/05/21 at 06:46 PM revealed housekeeping was responsible for cleaning the ceiling vents and they were cleaned daily. She explained the vents could be cleaned and then in 15 minutes they did not look like they had been cleaned. An interview with the former part-time maintenance staff member on 08/06/21 at 11:35 AM revealed he worked at the facility for 60-70 days. He explained he was hired to assist the Maintenance Director fix plaster and paint walls. The former staff member stated he received a paint and patch list from the Maintenance Director and then if other maintenance concerns arose the Maintenance Director told him what to do. He explained that system worked fine as long as the Maintenance Director was there on a daily basis but if he did not work the former staff member was unsure of what needed to be done.	F 584		
F 602 SS=G	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review and resident, staff, and the responding Police Officer interviews, the facility staff failed to report a resident kept a large sum of money on his person which put him at high risk for abuse, exploitation, and	F 602	1. The facility staff failed to report that Resident #98 kept a large sum of money on his person which put him at high risk for abuse, exploitation, and misappropriation and failed to prevent	9/20/21

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F 602	Continued From page 10 misappropriation and failed to prevent misappropriation of resident property when the money was removed from his pant pocket and stolen by an individual for 1 of 5 residents reviewed for abuse (Resident #98). The findings included: Resident #98 was admitted to the facility on 10/7/20 with diagnoses including incomplete paralysis of all four limbs and spasticity (condition in which muscles stiffen or tighten preventing normal movement). Resident #98 was listed as his own Responsible Party on the face sheet of his medical record and the first Power of Attorney (POA) listed on his advance directive. The quarterly Minimum Data Set (MDS) dated 5/19/21 assessed Resident #98 as being cognitively intact. Assistance needed for activities of daily living was assessed as requiring total assistance bed mobility, transfers, eating, and toilet use. There was no upper extremity range of motion impairment and impairment on both side of the lower extremities. Review of the 24-hour report revealed on 6/6/21 at 4:45 PM the facility became aware Resident #98 reported his money was stolen. The Police Department was notified, and an investigation started. Resident #98 was interviewed on 8/2/21 at 8:51 AM. Resident #98 revealed his named second POA had brought $9000.00 in cash to the facility upon his request. Resident #98 explained he was expecting to move out of the facility and after	F 602	misappropriation of Resident property when the money was removed from his pant pocket and stolen by an individual. Police called immediately to file report and investigate. Resident was able to identify individual and individual was arrested. 2. All residents that choose to keep large sums of money (greater then $30) have the potential to be affected. Additionally, an audit to be conducted by the Executive Director, Director of Nursing, and Social Worker to include interviews with all alert and oriented resident to ask if they keep money on their person. Resident Representatives will be contacted for the non-alert and oriented resident to ask if they have brought large sums of money to any of the residents. Residents and Resident Representatives will be educated on safety and risk involved and offered alternatives such as locked drawers, lock box, safe, or trust that the money may be kept. This audit will be completed by 9/20/2021. 3. Executive Director, Director of Nursing, and Assistant Director of Nursing will educate all staff on Abuse Policy and Misappropriation/Exploitation. Education to include reporting of any known abuse as well as identifying and reporting those that may be at risk for abuse i.e., seeing or knowing that someone has a large sum of money (Greater than $30). Education will be added to New Hire Orientation. Education to be completed by 9/20/2021.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 602	Continued From page 11 paying rent on a house he had $7200.00 left. Resident #98 kept the money in a double knotted sock. During the day the sock stayed in his pant pocket and at bedtime he asked Nurse Aide (NA) staff to put the sock in the pillowcase of the pillow he slept on. Resident #98 stated he didn't tell the Administrator about keeping a large amount of money because he preferred to keep his money close to him. Resident #98 explained the money was stolen from him on 6/6/21 by a male dressed in black scrubs who claimed he worked for the nursing agency the facility used. Resident #98 stated the male was able to locate him in the smoking area and appeared to know he had money in his pant pocket and removed the sock from his pocket then left the facility. Resident #98 revealed he identified the suspect on NA #4's social media. The male was somehow related to NA #4 and NA #5 and arrested by the police. Resident #98 provided the name of a resident who witnessed the theft and of NA staff who had seen or who he thought knew about the money in the sock. Resident #98 stated he experienced post-traumatic stress from the incident and didn't feel safe in the building and felt Administration didn't care and hadn't done anything about the incident. An interview was conducted on 8/05/21 at 11:33 AM with Nurse #12. Nurse #12 was the designated receptionist on 6/6/21 when a male she didn't recognize entered from the front door. She buzzed him in, and he told her he was from agency and gave his name. Nurse #12 checked the schedule kept at the front desk stating his name wasn't on it and that was not unusual, and the schedule frequently changed due to call outs. The male was wearing scrubs and no badge. The male said he was working on the south unit, so	F 602	Executive Director or designee will utilize questionnaire to interview staff on the Abuse Policy and reporting resident that may be at risk 10 staff member per week x 4 weeks, 5 staff members per week x 4 weeks, then 2 staff members per week x 4 weeks. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Executive Director monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Responsible Person: Executive Director Date of compliance is 9/20/2021	

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	345489	A. BUILDING _____ B. WING _____	C 08/13/2021

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she gave him directions and he proceed that way. When the male came back, he was pushing the door and said he needed to go out to his car. She buzzed the door open for him and he exited the facility to the parking lot. Resident #98 was coming up the hallway saying something, but Nurse #12 couldn't hear what until he got to the front desk and stated that guy robbed me. The police were called and she thought Resident #98 told her it was around $7000.00 that was stolen. Nurse #12 stated she wasn't aware Resident #98 had a large amount of money on his person. Now agency staff must wear a badge and provide their ID and those were scanned and kept in a log book at the front desk along with the schedule to verify they are agency assigned to work. The person at front desk makes copies of agency staff IDs and dates the copy and places in the logbook.

Review of the progress note written by the Social Worker on 6/18/21 revealed after meeting with his caseworker Resident #98 requested to receive psychotherapy services and an order was requested.

A psychotherapy note dated 7/29/21 revealed Resident #98 reported he didn't want to participate in psychotherapy. The note read in part, "today is his 3rd week in a row he has declined psychotherapy and was assessed if he wanted to continue services or would like to discharge. He reports doing well and wants to discharge from psychotherapy."

An interview was conducted with the person listed as the second POA on 8/06/21 at 11:57 AM. The POA confirmed she brought $10,000.00 in cash and gave the money to Resident #98. The POA

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didn't recall the exact date the money was brought to the facility and explained Resident #98 wanted the money because he had expected to be discharged, so she brought the money to the facility. The POA didn't tell anyone about bringing the money to the facility. After the robbery Resident #98 told the POA he was robbed approximately 20 to 30 minutes after asking NA #4 to put the sock of money in his pant pocket.

An interview was conducted on 8/10/21 at 9:45 AM with NA #2. NA #2 previously worked 2nd shift at the facility and had provided care to Resident #98 but wasn't there the day of the robbery. NA #2 revealed she counted the money when it was first brought to the facility and stated there was $9000.00 in cash. On the day NA #2 counted the money she placed the stack of money in plastic bag and put the bag in a knotted sock then in the pocket of Resident #98's pants. Afterwards when NA #2 assisted Resident #98 out of bed she would remove the sock from his pillowcase and place the money in his pant pocket. NA #2 didn't share with anyone else Resident #98 had $9000.00 in cash and stated, "I told no one." NA #2 revealed there were 2 other NA staff who also knew about Resident #98's money but couldn't recall their names. NA #2 explained she didn't tell anyone about the money and Resident #98 was able to make his own decisions and she did not recall when it was brought to the facility or when she counted it.

An interview was conducted with NA #4 on 8/10/21 at 4:34 PM. NA #4 revealed she and NA #5 (a family member) both worked for the staffing agency the facility used and 6/6/21 was her second day at the facility and first day caring for Resident #98. NA #4 explained on 6/6/21 around

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lunch time she and NA #5 used a mechanical lift to provide total assistance getting Resident #98 out of bed. Resident #98 asked NA #4 to reach under his pillow for a sock and place it inside his pant pocket. NA #4 stated she could tell there was something in the sock but couldn't see what and Resident #98 didn't tell her. NA #4 revealed Resident #98 was fed lunch by NA #5 who needed total assistance with eating and couldn't feed himself. NA #4 revealed she had not heard about any money until after the robbery and she repeated several times others knew about the money.

Multiple attempts to interview NA #5 were unsuccessful.

An interview was conducted on 8/09/21 at 4:31 PM with NA #11. NA #11 revealed Resident #98 told her he had $7000.00 before the incident happened and that he kept in a sock he tied in a knot. NA #11 revealed she didn't see the money but did see the sock and stated she could tell it was a large sum of money by the shape and described it looked like a big stack of money. Resident #98 would have NA #11 put the sock of money in his nightstand drawer which he had a key to lock. NA #11 would lock the drawer and put the key in container kept on top of the nightstand. When NA #11 would get Resident #98 out of bed he asked her to get his money out of the locked drawer and put it in his pocket. NA #11 revealed she didn't question the fact Resident #98 kept a large sum of money in his room and on his person stating he was of sound mind.

An interview was conducted on 8/10/21 at 5:13 PM with NA #3. NA #3 revealed she had provided care for

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Resident #98 but wasn't told about the money. When NA #3 put Resident #98 to bed, he asked her to remove the sock from his pant pocket and place it in the pillowcase of the pillow behind his head. NA #3 revealed the sock appeared thick and she could tell it was money by the way it felt and by how protective and close Resident #98 kept the sock to his person. NA #3 revealed she started seeing the sock sometime in May but was unsure of exactly when and stated he didn't have it long. NA #3 explained when Resident #98's plans to discharge from the facility changed that was when she recalled seeing the sock. NA #3 didn't discuss this with anyone at or outside the facility.

An interview was conducted on 8/12/21 at 1:42 PM with NA #6. NA #6 revealed she had seen Resident #98's money, which appeared to be a lot, but didn't know how much cash there actually was. NA #6 described Resident #98 had several stacks of money separated and banded together that were kept in a knotted sock. NA #6 explained at night whoever put Resident #98 to bed would place the sock in his pillowcase and whoever got him up would put the sock in his pant pocket. NA #6 stated she should have told someone about seeing that much money on a resident but felt like the Administrator or a Supervisor knew because Resident #98 was ready to leave the facility and in process of getting his own apartment.

The Police Officer (PO) who responded to the robbery was interviewed on 8/11/21 at 3:29 PM. The PO revealed the suspect was able to gain access to Resident #98 after being let in the facility by giving a false name and stating he worked for the nursing agency used by the facility. Resident #98 identified the suspect on NA

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#4's social media who was also related to NA #4 and NA #5. The suspect was brought in for an ID line up, Resident #98 identified him as the perpetrator, and an arrest was made.

An interview was conducted on 8/03/21 at 1:17 PM with the Administrator. The Administrator revealed NA #4 and NA #5 both worked for the agency company used by the facility and had worked the day of incident. The Administrator was unable to get an interview from either one. NA #4 called the facility on 6/7/21 and began screaming at the Administrator stating she and NA #5 had not stolen any money. The Administrator called the agency company and requested neither NA #4 nor NA #5 return to the facility.

A follow up interview was conducted on 8/11/21 at 11:47 AM with the Administrator. The Administrator explained Resident #98 felt like someone from the facility had tipped off the robber but was unsure who. After her 5- day investigation Resident #98 did share with her he thought NA#4 and NA #5 had tipped someone off because they were the 2 newest staff. The Administrator explained Resident #98 shared with her that other staff members at the facility were aware he had money, but he didn't think they knew how much and didn't name anyone who had counted or seen his money. After the incident, employees were trained, and her in-service included educating staff to report to her or the Social Worker (SW) when they see a resident with a lot of money. Either her or the SW would meet with the resident and ask if they would like to put the money in the business office safe or lock in their nightstand and also educated not to show the money to others if they chose not to put in the safe.

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F 602	Continued From page 17 An interview was conducted on 8/12/21 at 10:19 AM with the Administrator. The Administrator revealed the staff she interviewed thought Resident #98 had money but didn't know how much and no one ever reported anything to her. The Administrator stated if NA #2 counted $9000.00 in cash for Resident #98 she hoped NA #2 would report that to her even though Resident #98 was able to make his own decisions. The Administrator stated if any of the NA staff had informed her Resident #98 had a large amount of money he was keeping at the facility, she would've told him the money needed to be locked up in the safe. In addition, if Resident #98's second POA would've informed her she brought a large sum of money to the facility, she would've told the POA to take it back. The Administrator confirmed when NA#2 counted Resident #98's money and allowed him to keep a large sum of money on his person, he was put at risk for misappropriation of property.	F 602		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced	F 607		9/20/21

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F 607	Continued From page 18 by: Based on record review and resident and staff interviews, the facility failed to implement their abuse policy and complete a thorough investigation for misappropriation of resident property to include interviews from witnesses after a large sum of money was reported stolen for 1 of 5 residents reviewed for abuse (Resident #98). The findings included: The facility's abuse policy titled, "Abuse Prevention, Intervention, Reporting, and Investigating" revised on 2/2021 read in part: V. Procedure- #6 Investigation: a. it is our policy that reports of abuse including misappropriation of property are promptly and thoroughly investigated; G. II. review the resident's record to determine events leading up to the incident. G. VII interview family members and visitors as appropriate. H. general guidelines for interviewing that are encouraged be incorporated in an investigation include: IV. Witness reports were documented in writing by the investigator and signed and dated by both the interviewer and witness. A copy of each report is attached to the Abuse Investigation Report Form. Review of the initial allegation revealed on 6/6/21at 4:45 PM the facility became aware of misappropriation of property when Resident #98 reported his money was stolen. The Police Department was notified, and an investigation started. The investigation named the Administrator as the investigator. A review of the facility's investigation revealed no documentation of an interview with the person	F 607	1. The facility failed to implement their abuse policy and complete a thorough investigation for misappropriation of resident property to include interviews from witnesses after a large sum of money was reported stolen for 1 of 5 residents reviewed for abuse (Resident#98). 2. 100% Audit was completed by the Executive Director for all allegations of abuse and/or neglect submitted in the last 30 days 8/6/2021-9/7/2021, to determine if all 24- & 5-days reports were thoroughly investigated to include full description of the alleged abuse or neglect, interviews with staff, residents, resident representatives as applicable. Audit to be completed by 9/8/2021, any identified issues to be corrected immediately. 3. The Leadership team (Executive Director, Director of Nursing, Assistant Director of Nursing, Unit Managers, Social Worker) to be reeducated by the Regional Clinical Consultant and the Regional Director of Operations on Abuse and Neglect/Incident Investigation Protocol. Educated on the use of the witness statement forms and Investigation Summary Tool. Education to be completed by 9/20/2021. The Executive Director will send via email completed investigation tools to the Regional Director of Operations and Regional Nurse Consultant for review prior to submitting to the state agency to	

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F 607	Continued From page 19 named by Resident #98 who brought his money to the facility. The investigation was also missing an interview with Nurse Aide (NA) #2 who alleged she had counted Resident #98's money. An interview was conducted with Resident #98 on 8/2/21 at 8:51 AM. Resident #98 revealed the person named as his second POA brought $9000.00 in cash to the facility. After spending some of the money Resident #98 stated he had approximately $7200.00 in cash he kept in a sock. Resident #98 would ask NA staff to put the sock either in his pant pocket or in the pillowcase of the pillow he slept on. Resident #98 revealed on 6/6/21 his money was stolen from him by a male dressed in black scrubs who appeared to know he had money in his pant pocket and was able to remove the sock from his pocket then left the facility. Resident #98 provided the name of NA #2 who he thought saw and/or knew about the money he kept in the sock prior to being stolen. An interview with NA #2 on 8/10/21 at 9:45 AM revealed she had quit working at the facility either the week of or week before the robbery and wasn't there when it happened. NA #2 stated she saw and counted $9000.00 in cash then placed the money in plastic bag then put the money in a sock and placed the sock in Resident #98's pant pocket. NA #2 continued to place the sock of money either in the pillowcase or Resident #98's pant pocket upon his request. NA #2 revealed she told no one about the amount of money Resident #98 had. An interview was conducted on 8/04/21 at 9:52 AM with the Administrator. The Administrator revealed the reason misappropriation was unsubstantiated was because she nor the	F 607	ensure a thorough investigation was completed. This review will be Monday-Friday x 12 weeks. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Executive Director monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Responsible Person: Executive Director Date of compliance is 9/20/2021	

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F 607	Continued From page 20 Business Office were aware Resident #98 had money on his person and neither did his 2 primary nurses on 1st and 2nd shift. The Administrator confirmed a male entered the building on 6/06/21 and used a false name, stating he was here from the staffing agency to work on the south unit and was later notified by Resident #98 who stated the same male had stolen $7000.00 and the amount changed again to $5000.00. The Administrator explained Resident #98 did tell her he felt people at the facility were aware he had money but didn't think they knew how much and didn't name anyone who counted or seen his money. A second interview was conducted on 8/12/21 at 10:19 AM with the Administrator. The Administrator explained her investigation included interviews with people who had worked with Resident #98 over the last 72 hours prior to his money being stolen. A meeting was also held with Resident #98 and his second named POA who brought the money to the facility to discuss what happened, how much money the second named POA brought in and why bring that amount of money to the facility without reporting to the Administrator or the Business Office. The Administrator revealed she didn't include their meeting as part of her investigation.	F 607		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.	F 636		9/20/21

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

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive

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F 636	Continued From page 22 assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete the Minimum Data Set (MDS) within 14 days of a resident's admission for 1 of 3 sampled residents (Resident #410). Findings Included: Resident #410 was admitted to the facility on 7/20/21with a diagnosis of necrotizing (death of tissue) soft tissue infection of the sacrum. Resident #410's admission Minimum Data Set Assessment dated 7/30/21 revealed the MDS was in progress. The MDS was due to be completed on 8/2/21 and on 8/11/21 it was not completed. During an interview by phone with MDS Nurse #1 on 8/11/21 at 11:10 AM stated she knew Resident #410's MDS was late but she could not help it. She stated she had been out of work most of the month of July. In an interview on 08/11/21at 11:42 AM with the	F 636	1. The facility failed to complete the Minimum Data Set (MDS) within 14 days of a resident #410 admission Resident #410 MDS was completed on 8/24/2021. 2. All current residents MDS will be reviewed Regional MDS Consultant by 9/20/21 to ensure MDS was completed within the required timeframe. 3. Regional MDS Consultant will educate MDS nurses on completing the comprehensive MDS within the required timeframe. This education will be completed by 9/20/2021. Director of Nursing will audit 5 comprehensive MDS weekly to ensure MDS is completed within the required timeframe. The audit will be conducted weekly x 12 weeks Executive Director will review the results of the weekly audit to ensure	

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F 636	Continued From page 23 DON and the Administrator they verified that MDS Nurse #1 had been out of work most of July 2021. They stated they just hired a new MDS nurse, but she had only been working a few days. They stated it was their expectation that Minimum Data Set assessments be completed according to the federal regulations and company policy regarding completion and timing.	F 636	comprehensive MDS are completed within the required timeframe 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. Date of Compliance 9/20/2021. 5. Person Responsible: Executive Director and Director of Nursing Date of compliance 9/20/2021	
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to identify a resident with significant	F 637	1. Facility failed to identify that Resident #54 had a significant change and failed to	9/20/21

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F 637	Continued From page 24 changes in status and failed to complete a significant change in status Minimum Data Set (MDS) assessment for 1 of 2 residents reviewed for decline (Resident #54). Findings included: Resident #54's active diagnosis included: Dementia, Alzheimer's, and Failure to Thrive. Review of the admission MDS dated 2/6/21 revealed Resident #54 required limited assistance of 1 staff for transfers and toileting. She required extensive assistance of 1 staff for bed mobility. A review of the quarterly MDS dated 5/8/21 revealed Resident #54 required total dependence of 1 staff for bed mobility and toileting, while transfer activity did not occur. An interview was conducted with Nurse Aide #6 on 8/3/21 at 9:21 am. She stated Resident #54 was totally dependent on staff with activities of daily living (ADL) prior to February 2021. The MDS Nurse #1 was interviewed on 8/2/21 at 3:37 pm. She stated if a resident had a decline in 2 or more areas of ADL then a significant change in status assessment should be completed. The MDS nurse stated Resident #54's ADL decline from February to May would have indicated a significant change assessment. She stated MDS Nurse #2 completed the MDS assessment for Resident #54 in May 2021. An interview conducted with the MDS Nurse #2 on 8/4/21 at 10:42 am revealed she did not complete a significant change assessment for Resident #54 because she did not have an	F 637	complete significant change in status Minimum Data Set (MDS) assessment for Resident # 54. Resident #54 significant change will be completed by 9/10/2021. 2. All current residents MDS will be reviewed Regional MDS Consultant by 9/20/2021 to ensure MDS was completed within the required timeframe. 3. Regional MDS Coordinator will educate MDS nurses on completing the significant change MDS within the required timeframe. This education will be added to new hire packet. This education will be completed by 9/20/2021. MDS Coordinator will audit 5 significant change MDS weekly to ensure MDS is completed within the required timeframe. This audit will be conducted weekly x 12 weeks. Executive Director will review the results of the weekly audit to ensure significant change MDS are completed within the required timeframe. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Executive Director monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Person Responsible: Executive	

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F 637	Continued From page 25 actual, physical decline from she was admitted. The MDS Coordinator #2 stated when looking at ADL coding sheets, Resident #54 had several incidents of total dependence from February to May 2021. She indicated a significant change assessment was performed when a decline/improvement occurred in at least 2 late loss ADL. During an interview with the Director of Nursing (DON) on 8/4/21 at 8:29 am, she stated Resident #54's ADL decline from February to May of 2021 would have warranted a significant change assessment. The DON stated the assessment was not completed due to staffing issues and not having a full-time MDS Nurse available. An interview conducted on 8/5/21 at 9:02 am with the Administrator revealed a significant change assessment should have been performed after Resident #54's ADL decline was observed. She stated she was not sure why it was not completed.	F 637	Director Date of compliance is 9/20/2021	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessments in the areas of Preadmission Screening and Resident Review (PASRR), falls and date of death for 3 of 7 sampled residents reviewed for PASRR, accidents and closed record review (Residents	F 641	1. The facility failed to accurately code the Minimum Data Set (MDS) for Residents #38 in the area of Preadmission Screening and Resident Review (PASRR), #70 in the area of falls, and #111 in the area of date of death. Resident #38 MDS will be modified by	9/20/21

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F 641	Continued From page 26	F 641		

#38, #70 and #111).

Findings included:

1. Resident #38 was admitted to the facility on 03/05/21 with diagnoses that included bipolar disorder.

Review of a PASRR Level II Determination Notification letter dated 01/25/21 revealed Resident #38 had a time-limited Level II PASRR with an expiration date of 04/25/21.

The admission Minimum Data Set (MDS) dated 03/18/21 indicated that Resident #38 had not been evaluated by Level II PASRR and determined to have a serious mental illness and/or intellectual disability.

During a telephone interview on 08/09/21 at 1:04 PM, MDS Nurse #1 explained the SW notified her via email of any resident with a Level II PASRR for coding the MDS assessments. MDS Nurse #1 explained if she did not receive an email from the SW regarding a resident's Level II PASRR status, then it was assumed the resident was a Level I PASRR and the MDS was coded accordingly. MDS Nurse #1 could not recall if she had been notified by the SW that Resident #38 had a Level II PASARR effective 01/25/21. She added the admission MDS dated 03/18/21 for Resident #38 was coded incorrectly and a modification would need to be submitted to accurately reflect she had a Level II PASRR.

During an interview on 08/03/21 at 9:49 AM, the Social Worker (SW) explained she kept track of residents with a Level II PASRR and notified the MDS Nurses for them to be aware to code it on

9/10/2021. Resident #70 MDS was modified on 9/3/2021. Resident #111 MDS was modified on 9/3/2021.

2. MDS Coordinator will review residents that currently have a level II PASRR for accuracy of MDS. Residents with a Fall with Major Injury in the last three months MDS with be reviewed for accuracy and residents that have expired in the facility in the last three months MDS will be reviewed for accuracy. If discrepancies are found MDS are to modify assessments. This review will be completed by 9/20/2021.

3. Regional MDS Consultant will educate MDS nurses on completed MDS assessment accurately when a resident has a level II PASRR, Fall with Major Injury, as well as correct date of death. The education will be added to new hire packet. This education will be completed by 9/20/2021.

Director of Nursing will audit 5 significant change, quarterly and annual MDS assessments to ensure assessment accurately reflects when a resident has a Level II PASRR, Fall with major injury, as well as correct date of death. This audit will be conducted weekly x 12 weeks.

4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the

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F 641	Continued From page 27 the MDS assessments. The SW added she had somehow overlooked Resident #38's Level II PASRR when she was admitted to the facility and therefore, the MDS Nurse was not notified. During an interview on 08/05/21 at 5:30 PM, the Administrator stated her expectations were for MDS assessments to be accurately coded and explained due to human error, Resident #38's Level II PASRR had been entered incorrectly in the system as a Level I PASRR and as a result, her admission MDS assessment dated 03/18/21 was incorrectly coded. 2. Resident #70 was admitted to the facility on 05/02/18 with multiple diagnoses that included an autoimmune disease that affects the central nervous system. Review of a nurse progress note dated 05/17/21 read in part, Resident #70 slid out of the wheelchair during transport in the facility van with minor injury to his leg that was treated with topical antibiotic ointment and covered with a dry dressing. No other injuries were noted. Review of the x-ray results dated 5/19/21 revealed Resident #70 had a mildly displaced oblique (slanting) fracture of the distal tibia (inner bone between the knee and ankle) and nondisplaced (bone is broken but not out of alignment) fracture of the distal fibula (outer bone between the knee and ankle). The quarterly Minimum Data Set (MDS) dated 06/01/21 noted Resident #70 had one fall with no major injury since the prior MDS assessment dated 04/06/21.	F 641	interventions to determine if continued auditing is necessary to maintain compliance. 5. Responsible Person: Executive Director and Director of Nursing Date of compliance is 9/20/2021	

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F 641	Continued From page 28	F 641		

During a telephone interview on 08/09/21, MDS Nurse #1 explained she did not have time to review documentation in a resident's medical record, such as nurse progress notes or x-ray results, when completing MDS assessments and coded falls/injuries based off the incident reports completed by the nurse. MDS Nurse #1 was unable to access the incident report for Resident #70 but stated she was aware that he had sustained a fracture related to his fall on 05/17/21 and the quarterly MDS dated 06/01/21 should have been coded to reflect he had a fall with major injury. She added a modification would need to be submitted.

During an interview on 08/05/21 at 5:30 PM, the Administrator stated her expectations were for MDS assessments to be accurately coded and the MDS assessment dated 06/01/21 should have been coded to reflect Resident #70 had a fall with major injury due to his diagnoses of leg fracture.

3. Resident #111 was admitted to the facility on 05/10/18 with multiple diagnoses that included End-stage Renal Disease (ESRD).

The death in the facility Minimum Data Set (MDS) for Resident #111 completed and submitted on 07/23/20 noted an assessment reference date of 07/22/20. The MDS further noted a discharge date of 07/22/20 and listed Resident #70's discharge status as deceased.

Review of a nurse progress note dated 07/23/20 read in part, Resident #111 was found unresponsive with fixed and dilated pupils, no pulse and not breathing. Time of death verified at 1:30 AM.

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F 641	Continued From page 29 During a telephone interview on 08/09/21 at 1:04 PM, MDS Nurse #1 explained she received a daily census report from the business office noting any death in the facility. MDS Nurse #1 stated she completed the death in facility MDS assessment based off the information listed on the daily census report and did not review nurse progress notes in the resident's medical record to clarify the actual date of death. She added a modification would need to be submitted to accurately reflect Resident #111's date of death as 7/23/20. During an interview on 08/05/21 at 5:30 PM, the Administrator confirmed Resident #111 passed away at the facility on 07/23/20 and stated the MDS assessment should have been accurately coded to reflect the correct date of his death.	F 641		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible	F 644		9/20/21

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F 644	Continued From page 30 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 request a Preadmission Screening and Resident Review (PASRR) before the expiration date for 1 of 1 resident reviewed with a Level II PASRR (Resident #38). Findings included: Resident #38 was admitted to the facility on 03/05/21 with diagnoses that included bipolar disorder. The admission Minimum Data Set (MDS) dated 03/18/21 indicated that Resident #38 had not been evaluated by Level II PASRR and determined to have a serious mental illness and/or intellectual disability. Review of a PASRR Level II Determination Notification letter dated 01/25/21 noted Resident #38 was evaluated and assigned a time-limited Level II PASRR with an expiration date of 04/25/21. Further review revealed in part, if Resident #38's nursing facility placement was expected to extend beyond the expiration date, the nursing facility was responsible for initiating further screening through the Level II evaluation process within 5 calendar days of the PASRR expiration date. During an interview on 08/03/21 at 9:49 AM, the Social Worker (SW) confirmed she was responsible for initiating and coordinating Level II PASRR reviews. The SW explained she kept	F 644	1. Facility failed to request a Preadmission Screening and Resident Review (PASRR) assessment before the expiration date of the PASARR Level II for Resident #38. Resident #38 PASARR level II was submitted on 8/2/2021, approved on 8/6/2021 and was given a permanent PASARR. 2. A PASRR audit will be conducted by the Social Worker for all current residents to ensure PASRRs are not expired and up to date. This audit will be completed by 9/20/2021. 3. Social Worker was to be educated by the Executive Director on expectation that PASRRs are not to expire and remain up to date. This education will be added to new hire packet. This education will be completed by 9/20/2021. Social Worker will audit all current residents PASRR to ensure they are not expired and remain up to date weekly x 12 weeks. Executive Director will review weekly PASRR audit to ensure PASRRs aren□t expired and remain up to date. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to. QAPI by the	

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F 644	Continued From page 31 resident PASRR Notification Letters in a notebook and flagged the ones with expiration dates as a reminder for her to follow-up on before the PASRR expired. The SW stated Resident #38's Level II PASRR was somehow overlooked upon her admission and therefore, a request for a Level II PASRR screening was not submitted and Resident #38's PASRR expired on 04/25/21. During an interview on 08/03/21 at 10:35 AM, the Administrator explained the SW was responsible for keeping track of residents who had Level II PASRR and requesting PASRR screenings when needed and prior to the expiration date, if applicable. The Administrator confirmed she was made aware that Resident #38's Level II PASRR had expired on 04/25/21 and explained it was overlooked due to human error.	F 644	Executive Director monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. Date of compliance 9/20/2021 5. Person Responsible: Executive Director	
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not	F 656		9/20/21

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F 656	Continued From page 32 provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop comprehensive, individualized care plans that addressed the areas of Preadmission Screening and Resident Review (PASRR), smoking and actual pressure ulcers for 3 of 6 sampled residents reviewed for PASRR, accidents and pressure ulcer/injury (Resident #38, #17 and #44). Findings included: 1. Resident #38 was admitted to the facility on 03/05/21 with diagnoses that included bipolar disorder.	F 656	1. Facility failed to develop a comprehensive, individualized care plan for Resident # 38 that addressed the area of Preadmission Screening and Resident Review (PASRR), for Resident #17 that addressed smoking, and for Resident #44 that addressed actual pressure ulcers. Comprehensive, individualized care plan will be completed for Resident #38 by 9/20/2021. Comprehensive, individualized care plan will be completed for Resident #17 by 9/20/2021. Comprehensive, individualized care plan will be completed for Resident #44 by	

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F 656	Continued From page 33 Review of a PASRR Level II Determination Notification letter for Resident #38 and dated 01/25/21 revealed nursing facility placement was appropriate for a 90-day period with specialized services that consisted of psychiatric services provided by a Psychiatrist and rehabilitative services. The admission Minimum Data Set (MDS) dated 03/18/21 indicated that Resident #38 had not been evaluated by Level II PASRR and determined to have a serious mental illness and/or intellectual disability. Review of Resident #35's active care plans, last reviewed/revised 07/05/21, revealed no care plan that addressed her Level II PASRR status or the specialized services needed as described in the PASRR Level II Determination Notification. During interviews on 08/03/21 at 9:49 AM and 08/09/21 at 2:58 PM, the Social Worker (SW) explained she kept track of all residents with a Level II PASRR and was responsible for developing a PASRR care plan. The SW added she had somehow overlooked Resident #38's Level II PASRR when she was admitted to the facility and therefore, a care plan was not developed. During an interview on 08/05/21 at 5:30 PM, the Administrator explained due to human error, Resident #38's Level II PASRR had been entered incorrectly in the system as a Level I PASRR and as a result, a care plan was not developed but should have been. 2. Resident #17 was admitted to the facility	F 656	9/20/2021. 2. All current residents with a PASRR Level II, Smoker, and with Pressure injuries will be audited by the Interdisciplinary Team (IDT) to include Executive Director, Director and Assistant Director of Nursing, Unit Coordinators, Wound Nurse, Social Worker, and MDS Coordinators to ensure a comprehensive, individualized careplan for these areas are completed. This audit will be completed by 9/20/2021. 3. Regional MDS Consultant will educate MDS nurses on completing comprehensive, individualized care plans on or before the 21st day of stay for the resident and updating the care plan during the quarterly assessment, as well as individualizing care plans with changes. This education will be added to the new hire packet. This education will be completed by 9/20/2021. Director of Nursing or designee will audit 5 residents per week to ensure they have an accurate complete comprehensive individualized care plan. This audit will be completed weekly x 12 weeks. Executive Director will review the results of the weekly audit to ensure the completion and individualization of the comprehensive care plans. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to. QAPI by the	

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F 656	Continued From page 34 01/05/19 with diagnoses including traumatic spinal cord dysfunction and gastroesophageal reflux disease (GERD). A document titled "Care Plan Detail" dated 06/08/20 stated Resident #17 chose to smoke cigarettes. No goals or interventions were present on the document. Review of the annual Minimum Data Set (MDS) dated 01/23/21 revealed Resident #17 was cognitively intact and used tobacco. A "Safe Smoking Evaluation" was performed 07/27/21 and Resident #17 was deemed to be a safe smoker. An interview with the Administrator on 08/05/21 at 06:15 PM confirmed there was not a completed care plan for smoking for Resident #17 and there should be a care plan for smoking present in Resident #17's chart. The Administrator stated MDS nurses were responsible for developing care plans. An interview with MDS Nurse #1 on 08/10/21 at 04:06 PM revealed she would have been the person responsible for completing the smoking care plan for Resident #17 and it just got missed. 3. Resident #44 was admitted to the facility 01/22/21 with diagnoses including seizure disorder and respiratory failure. Review of the quarterly Minimum Data Set (MDS) dated 05/10/21 revealed Resident #44 was severely cognitively impaired and had 2 stage 3 (full thickness skin loss involving damage to the subcutaneous tissue) present on admission, 3 stage 4 (full thickness skin loss) present on	F 656	Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. Date of compliance is 9/20/2021 5. Person Responsible: Executive Director and Director of Nursing	

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F 656	Continued From page 35 admission, and 3 unstageable pressure ulcers present on admission. Review of the pressure ulcer care plan last reviewed 05/04/21 revealed Resident #4 was at high risk for pressure ulcers with a goal of remaining free from new skin breakdown through the next review date. Further review of Resident #44's care plan did not reveal a care plan for actual impairment to skin integrity. An interview with the Administrator on 08/05/21 at 06:15 PM confirmed there was no care plan in Resident #44's chart for actual impairment to skin integrity. She stated Resident #44 should have had a care plan developed for actual impaired skin integrity and MDS nurses were responsible for developing care plans. An interview with MDS Nurse #1 on 08/10/21 at 04:03 PM revealed she initiated care plans for residents who were at high risk for developing skin integrity and if a resident had actual impaired skin integrity the wound care nurse was responsible for developing a care plan for impaired skin integrity. An interview with Wound Nurse #1 on 08/10/21 at 04:06 PM revealed she had been working as the wound nurse on and off for the past 3 to 4 months. She stated she was not aware of any expectation from Nursing Administration for her to develop care plans for actual skin impairment and thought MDS nurses developed and completed all care plans.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677		9/20/21

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F 677	Continued From page 36 §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to check for incontinence or provide incontinence care to a resident for 1 of 7 sampled residents dependent on staff for activities of daily living (Resident #77). Findings included: Resident #77 was admitted to the facility on 7/01/20 with diagnoses which included diabetes mellitus and dementia. The quarterly Minimum Data Set (MDS) dated 7/07/21 assessed Resident #77's cognition as being severely impaired and required extensive assistance with bed mobility, transfers, and toilet use. The bowel and bladder section of the MDS assessment revealed Resident #77 was always incontinent of bladder and bowel. The care plan last reviewed on 7/27/21 recognized Resident #77 was incontinent of bowel and bladder and required staff assistance with managing incontinence with the goal to manage incontinence with dignity through the next review. Interventions included provide appropriate size pad and brief, offer toileting assistance and/or incontinence care frequently, an provide prompt incontinence care with each episode. On 8/01/21 at 1:39 PM and observation with Nurse #7 was made of Resident #77 in bed.	F 677	1. Facility failed to check incontinence or provide incontinence care to resident #77. Resident #77 was provided incontinent care on 8/1/2021 by NA #9. 2. An audit was conducted on 8/1/2021 of all incontinent residents to ensure incontinence care was being provided. This audit was completed by Unit Coordinators. 3. All Licensed Nurses, Certified Nursing Aides, and Nurse Aids in Training will be in-serviced by the Director of Nursing and/or Assistant Director of Nursing on the policy and procedure for incontinence care. To include effective incontinent care, timely incontinence care and toileting assistance. Education will be added to New Hire Orientation. Education to be completed by 9/20/2021. The Director of Nursing or designee will conduct audits for incontinence care by observing 15 residents per week x 4 weeks, 10 residents per week x 4 weeks, then 5 residents per week x 4 weeks. The Executive Director will review the results of the weekly audit to ensure that incontinence care was provided. 4. Data obtained during the audit	

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F 677	Continued From page 37 Resident #77 was wearing an incontinence brief that appeared firm as if full and a strong odor resembling urine was noted. Nurse #7 stated she would notify Resident #77's Nurse Aide (NA) incontinence care was needed and left the room. On 8/01/21 at 1:52 PM an interview was conducted with NA #9. NA #9 stated she arrived to the facility at 9:00 AM and was assigned to provide care to Resident #77 but hadn't had time to provide incontinence care to Resident #77 because she was assigned approximately 20 or more residents and it was nearly impossible to provide her assigned residents with the care they need. An interview was conducted on 8/05/21 at 10:40 AM with NA #7 who revealed she worked the unit with NA #9 on 8/01/21 where Resident #77 resided. NA #7 stated she didn't provide incontinence care for Resident #77 on 8/01/21. NA #7 revealed with only 2 NA staff members on the unit it could be challenging to provide incontinence care timely. An observation was conducted on 8/01/21 at 2:00 PM of NA #9 getting Resident #77 ready for a bed bath. NA #9 removed the bed covers and it appeared Resident #77 was wearing the same incontinence brief that remained firm as if full and a strong odor of urine was noted. When NA #9 unfastened Resident #77's incontinence brief it was heavily saturated with urine and there was a second incontinence brief that appeared heavily saturated with urine. During incontinence care Resident #77's peri area didn't appear red or irritated.	F 677	process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Person Responsible: Director of Nursing Date of compliance is 9/20/2021	

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F 677	Continued From page 38 On 08/01/21 at 3:10 PM the Administrator revealed there were 2 NA call outs and typically the unit had 3 to 4 NA staff. The Administrator revealed she was able to get 2 NA staff to come in and help with resident care and at approximately 12:00 PM one NA was assigned to help on the unit where Resident #77 resided. On 8/01/21 at 3:14 PM a second interview was conducted with Nurse #7. Nurse #7 revealed she asked NA #9 to provided incontinence care for Resident #77. Nurse #7 stated she did not provide incontinence care for Resident #77. An interview was conducted on 8/05/21 at 11:02 AM with Unit Manager (UM) #2. UM #2 stated resident care should be provided timely and residents should be checked and not left incontinent for a long period of time. UM #2 was unsure of what happened with Resident #77's care on 8/01/21 and preferred not to comment. An interview was conducted with the Administrator on 8/05/21 at 6:17 PM. The Administrator stated staffing on 8/01/21 was challenging and if Resident #77 had a history of large incontinent episodes and didn't use the call light to ask for assistance that could be the reason her incontinent brief was heavily saturated on 8/01/21. The Administrator stated she didn't think Resident #77 went without incontinence care for a long period of time but ideally NA staff check on residents every 2 hours to assist with needs.	F 677		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care	F 684		9/20/21

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F 684	Continued From page 39 Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to remove a dressing left in place for 14 days and reassess the skin and obtain treatment orders from the physician for scheduled wound care for 1 of 2 residents reviewed for skin conditions (Resident #66). The findings included: Resident #66 was admitted to the facility on 5/23/15 with diagnoses which included cancer lesions on the right shoulder, Alzheimer's, and dementia. The most recent Minimum Data Set (MDS) dated 5/28/21 assessed Resident #66's cognition as being severely impaired and activity of daily living needs as total assistance with bed mobility, transfers, and toilet use. The MDS indicated Resident #66 had no other skin problems with treatments in place to apply ointments and medications. Resident #66's care plan last revised on 6/12/21 identified a history of cancer growths to the right shoulder with the goal the growths remained free of infection through the next review. Interventions in place included treatments as ordered, observe the area daily for signs and symptoms of	F 684	1. Facility failed to remove a dressing left in place for 14 days and reassess the skin and obtain treatment orders from the physician for scheduled wound care for resident # 66. Physician order for treatment was obtained on 8/1/2021 and dressing changed for Resident #66. 2. Complete skin checks where completed for current residents to ensure no dressings or wounds present without physician ordered treatments. This audit will be completed by 9/20/2021 by nurse managers. 3. Director of Nursing and/or designee will educate wound nurse and licensed nurses on completing dressing changes as ordered by physician, as well as completing completing weekly skin checks. Certified nursing assistants and nurse aide in training will be educated to report to license nurse any skin alterations or any soiled dislodged dressings. Education will be added to New Hire Orientation. Education completed by 9/20/2021. Director of Nursing, unit managers and or	

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F 684	Continued From page 40 infection, pain, and changes in appearance and promptly report to the Medical Doctor (MD) or Nurse Practitioner (NP), and refer to a specialist as needed. Review of Resident #66's most recent skin assessments dated 7/20/21 and 7/27/21 indicated the skin was intact. Both assessments were completed by Nurse #5. An observation on 8/01/21 at 4:04 PM revealed Resident #66 resting in the bed on her right side. At the base of Resident #66's neck and right shoulder was a foam border dressing dated 7/19/21 with Nurse #5's initials. The dressing was not adhered to the skin to ensure the wound was protected. An interview and observation was conducted with Nurse #4 on 8/01/21 at 4:17 PM. Nurse #4 confirmed she was Resident #66's nurse and was not aware of a wound or any treatment orders. Nurse #4 observed the foam dressing was dated 7/19/21 and removed it to check the status of the wound. The back of the dressing was completely soiled with brown colored debris and reddish-brown colored drainage. The area of skin under the dressing appeared moist and pink to red in color with a dark red area in the center of the wound. The dark red area was approximately the size of pencil eraser with no odor and not actively bleeding. An interview was conducted with Unit Manager (UM) #1 on 8/01/21 at 4:30 PM. UM #1 observed the wound dressing and confirmed the dressing was dated 7/19/21 and not adhered to the skin to keep the wound protected. UM #1 observed the back of dressing was visibly soiled with blood	F 684	designee will audit 5 residents per week x 12 weeks to ensure no treatments are in place without physician orders. Executive Director will review the results of the audit weekly to ensure that treatments were completed as ordered. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Person Responsible: Director of Nursing Date of compliance is 9/20/2021	

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F 684	Continued From page 41	F 684		

colored debris and drainage with a small open area and the skin surrounding the open area was red to pink in color. UM #1 stated the nurse who initialed the dressing should have done an incident report and notified the MD to obtained treatment orders and expected either a Nurse Aide (NA) or nurse would've noted the dressing wasn't adhering to the skin or the date on the dressing was 7/19/21.

Review of Resident #66's physician orders revealed on 8/01/21 an order was written for fluorouracil 5% cream (used to treat superficial skin cancer). The order directed nurses to cleanse the area of the right shoulder and apply fluorouracil 5% cream topically and cover with a dry dressing daily and as needed for the diagnosis of neoplasm (an abnormal mass of tissue).

During an interview on 8/03/21 at 10:52 AM the NP revealed she was notified about Resident #66's wound when the facility called to obtain treatment orders on 8/01/21. Today was first time the NP saw the wound and described the area of surrounding skin was red to pink and the center of the wound with a scant amount of bloody drainage. The NP stated the wound didn't appear infected and she would need to review the medical chart for any notes Resident #66 was scratching the area or had a history of this type of wound. The NP stated she would expect either a nurse or NA would've seen the date on the dressing and expected the nurse to notify her to obtain treatment orders. The NP revealed having the dressing on for 14 days put the wound at risk for infection but indicated there were no signs the wound was infected, but she would refer Resident #66 to the wound clinic.

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F 684	Continued From page 42 An interview was conducted on 8/3/21 at 4:23 PM with Nurse #5. Nurse #5 confirmed she applied the dressing dated 7/19/21 and the skin wasn't open and it appeared as if Resident #66 had been scratching the area. Nurse #5 stated she made a nursing judgement to clean the area and cover with a dressing and didn't think it required further treatment therefore she didn't notify the MD or NP. Nurse #5 explained when she noted an open area on a resident's skin, she would notify the wound nurse who checked the skin and if needed obtained treatment orders. Nurse #5 confirmed she documented the skin assessment on 7/27/21. When asked if she observed the dressing, she applied on 7/19/21 was still in place did that trigger her to change the dressing or notify the MD or NP. Nurse #5 stated she didn't observe the area during her skin assessment on 7/27/21. An interview was conducted 8/05/21 at 6:28 PM with the Administrator. The Administrator revealed skin assessments should be done correctly and the protocol was if a new skin issue was identified the nurse would notify the MD and if needed obtain an order for treatment. The Administrator expected nurses not to leave a dressing on for 14 days and to follow the protocol for skin assessments.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with	F 686		9/20/21

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F 686	Continued From page 43 professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and Wound Care Nurse Practitioner (NP) interviews the facility failed to provide pressure ulcer care per physician orders for 1 of 4 residents (Resident #44) reviewed for pressure ulcer care. Findings included: Resident #44 was admitted to the facility 01/22/21 with diagnoses including seizure disorder and anxiety. Review of the quarterly Minimum Data Set (MDS) dated 05/10/21 revealed Resident #44 had 2 stage 3 (full thickness skin loss involving damage to the subcutaneous tissue) present on admission, 3 stage 4 (full thickness skin loss) present on admission, and 3 unstageable pressure ulcers present on admission. Review of Resident #44's treatment orders in part were as follows: a. Cleanse right lateral (side) calf wound with 0.5% dakin's solution (an antiseptic), pat dry, pack with dakin's soaked gauze, and cover with a dry dressing daily and prn (as needed) ordered 06/19/21	F 686	1. Facility failed to provide pressure ulcer care per physician orders for Resident #44. Resident #44 0.5% solution was ordered on 8/2/2021 and dressing change was provided per physician orders upon arrival of 0.5% solution. 2. An audit was conducted by the Wound care nurse to ensure that all resident with treatment orders had correct treatment available. Audit will be completed by 9/20/2021. 3. Director of Nursing and/or designee will educate wound nurse and licensed nurses on completing dressing changes as ordered by physician and if ordered dressing is not available on the process of notifying the physician for an alternate order. All Licensed nurses will be educated in orientation. Education completed by 9/20/2021. Director of Nursing, unit managers and or designee will audit 5 residents with treatments per week x 12 weeks to ensure physician ordered treatment in available.	

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F 686	Continued From page 44 b. Cleanse right ischial wound (the curved bone forming the base of each half of the pelvis) with wound cleanser, pat dry, pack with wet dakin's 0.5% solution moistened gauze, and cover with dry dressing daily ordered 7/21/21 c. Cleanse sacral wound (a triangular bone in the lower back form from fused vertebra) with wound cleanser, pat dry, pack with wet dakin's 0.5% solution moistened gauze, cover with dry gauze, and cover with dry dressing daily ordered 07/12/21 d. Cleanse left ischial wound with wound cleanser, pat dry, pack with wet dakin's 0.5% solution moistened gauze, cover with dry gauze, and cover with dry dressing daily ordered 07/12/21 e. Cleanse left calf wound with 0.5% dakin's solution, apply dakin's moistened gauze, cover with dry gauze, and secure with a foam dressing daily and prn ordered 06/22/21 An observation of the Nurse #9 on 08/02/21 at 02:15 PM performing wound care to Resident #44's right calf, right ischial wound, sacral wound, left ischial wound, and left calf wound revealed dakin's 0.25% solution was used for all wound care requiring dakin's solution instead of the ordered dakin's 0.5% solution. Nurse #9 removed the old dressing to Resident #44's left calf wound, cleaned the wound with dakin's 0.25% solution, applied dakin's 0.25% solution moistened gauze, and covered the wound with 2 foam dressings. No dry gauze was applied on top of the moistened gauze and the adhesive on the foam dressings was observed to be touching the wound bed. An interview with Nurse #9 on 08/02/21 at 03:56 PM revealed she did not normally perform wound	F 686	Executive Director will review the results of the audit weekly to ensure that treatments were completed as ordered. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Person Responsible: Director of Nursing Date of compliance is 9/20/2021	

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	345489	A. BUILDING _____ B. WING _____	C 08/13/2021

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F 686	Continued From page 45	F 686		

care but the Wound Care Nurse was on vacation so she was assisting with wound care. She stated she looked for dakin's 0.5% solution but could not find any so she used the dakin's 0.25% solution instead. Nurse #9 stated since the dakin's 0.5% solution was unavailable she should have notified the wound care provider and gotten an order to use dakin's 0.25% solution or other wound care product until the dakin's 0.5% solution was available. She stated she missed the step of applying dry gauze over the moistened gauze on Resident #44's left calf wound and did not see the adhesive from the foam dressings were touching the wound bed of Resident #44's left calf wound.

An interview with the Wound Care NP on 08/04/21 at 10:09 AM revealed she should have been notified dakin's 0.5% solution was not available when performing Resident #44's wound care and she could have given an order to use the 0.25% dakin's solution instead. She also stated if the dry gauze had been applied over the moistened gauze as ordered to Resident #44's left calf wound that would have prevented the wound bed from being in direct contact with adhesive. The Wound Care NP stated adhesive should never be in direct contact with a wound bed.

An interview with the Administrator on 08/05/21 at 06:15 PM revealed she expected nursing staff to follow physician's orders and if the dakin's 0.5% solution was not available the provider should have been notified and a new order obtained. She stated dry gauze should have been applied over the moistened gauze on Resident #44's left calf wound so adhesive did not touch the wound bed.

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F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff, resident, Radiologist and Manufacturer Representative interviews, the facility failed to ensure positioning and securement was according to manufacturer recommendations to provide a safe facility van transport for 1 of 5 sampled residents reviewed for accidents (Resident #70). During a facility van transport on 05/17/21, Resident #70 slid partially out of the wheelchair causing his knee and lower legs to hit the floor of the van, resulting in minor bruising noted to his knee and no reported pain. Resident #70 was assisted back to into his wheelchair without an assessment by a licensed nurse or medical professional. On 05/19/21, Resident #70 was sent to the hospital due to increased pain and subsequently diagnosed with a mildly displaced oblique (slanting) fracture of the distal tibia (inner bone between the knee and ankle) and nondisplaced (bone is broken but not out of alignment) fracture of the distal fibula (outer bone between the knee and ankle). Resident #70's leg was placed into a cast secondary to left tibia fracture and he returned to the facility the same day. Immediate Jeopardy began on 05/17/21 when	F 689	1. On 5/17/2021 at approx. 11:30am, Resident #70 was being transported in the facility□s van back to the facility following an appointment accompanied by Transport Driver #1 and Nurse Aide #1. During transport, Resident #70 informed Transport Driver #1 he was sliding out of his wheelchair. Transport Driver #1 immediately pulled the van over to the side of the road and both she and Nurse Aide #1 noted Resident #70 had slid down, but he was not completely out of his wheelchair. Transport Driver #1 reported that Resident #70 had his upper body (above the waist) was still in the wheelchair, being secured by the chest/lap belt. Per Transport Driver #1 Resident #70 right knee was on the floor of the van and his left leg was on the floor and underneath the footrest of the wheelchair. Transport Driver #1 and Nurse Aide #1 assisted Resident #70 back into wheelchair, making sure that his seat/lap belt and wheelchair were all secure and continued back to the facility. At approx. 12:30, Transport Driver #1 arrived back to the facility with Resident	9/20/21

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F 689	Continued From page 47 Resident #70 slid out of the wheelchair during a facility van transport and sustained a leg fracture. Immediate Jeopardy was removed on 08/10/21 when the facility implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of "D" (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) to ensure monitoring systems put into place are effective. Findings included: The undated manufacturer's instructions utilized by the facility and titled, "Vehicle Anchorages and Accessories for 4-Point Wheelchair Securement Systems," read in part: "Securing Wheelchair: Center wheelchair facing forward in securement zone. Attach front retractor or manual front anchorage points and lock them in place. If using deluxe or max retractors, ensure the retractors are used at the front. Completely pull out each webbing and attach J-hook to solid frame member. Attach rear retractors or rear manual tiedowns into floor anchorage points and lock them into place. Completely pull out each webbing and attach hook to solid frame member. Move wheelchair forward and back to remove webbing slack or manual tension webbing with retractor knobs. Lock wheelchair brakes (or power off electric chair). Attach retractable combination lap/shoulder belt: attach tongue on end of shoulder belt to buckle stalk closest to the wall. Pull the shoulder belt over occupant's chest and insert tongue into the buckle stalk closest to the aisle. Adjust shoulder belt height so that shoulder belt rests on occupant's shoulder, making sure the shoulder belt does not rub against the occupant's neck." The	F 689	#70. Transport Driver #1 notified Nurse #1 of Resident #70 sliding out of the wheelchair. In a nursing note by Nurse #1 on 5/17/2021 at 4:02pm read in part that Resident #70 returned from appointment with no new orders. Transport Driver #1 reported that Resident #70 slid out of wheelchair and had bruises to his leg. Resident #70 confirmed incident. Bruises on left leg cleaned with wound cleanser and covered with TAO and dry dressing, treatment provided by Nurse #1. Nurse #1 noted resident denied pain. Responsible Party contacted, no answer, nurse monitoring. Incident report, fall and pain assessment completed by Nurse #1. Nurse #1 reported that she completed an assessment which included checking for sign/symptoms of a fracture with no abnormalities noted other than the scratch and bruising to his left leg in which she treated with the TAO and a dressing. On 5/18/2021 at 2:24am Nurse #2 noted resident status post fall with bruise to left leg with no complaints of pain and no acute distress. On 5/18/2021 Nurse #1 reported during her shift (1st) that resident #70 complained of pain to left leg and was given Tylenol that she reported was effective, she also reported she assessed Resident #70 leg and there were no signs of obvious fracture and the only injury noted was the scratch and bruise to his left leg. On 5/19/2021 at 9:44 am Nurse #2 noted	

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F 689	Continued From page 48 manufacturer's instructions provided no guidance regarding occupants sitting on cushions or mechanical lift slings while they were seated in their wheelchair during transport. Resident #70 was admitted to the facility on 05/02/18 with multiple diagnoses that included an autoimmune disease that attacks the central nervous system, muscle weakness and depression. The quarterly Minimum Data Set (MDS) dated 06/01/21 assessed Resident #70 with intact cognition for daily decision making. The MDS noted he used a wheelchair for mobility, required limited staff assistance with locomotion and total staff assistance with transfers. The Resident Incident Report dated 05/17/21 at 12:00 PM noted Resident #70 slid out of the wheelchair while in the facility van during transport and sustained bruises to the left upper and lower shin that were treated with Topical Antibiotic Ointment (TAO) and dry dressing. The facility's investigation, dated 5/19/21 and completed by the Administrator, revealed in part: on 5/17/21 at approximately 11:30 AM, Resident #70 slid out of the wheelchair while in the facility van being transported back to the facility from an appointment. Resident #70's wheelchair was correctly secured with both chest/lap belt and four-point restraints. However, Resident #70 was noted to have a mechanical lift pad under him and no cushion in the wheelchair. The Transport Driver (TD) #1 was notified by Resident #70 that he was sliding out of the chair, she maneuvered the facility van to a safe location and once the van was stopped, she noticed that Resident #70's	F 689	bruising to left leg persist no complaints of pain or discomfort. On 5/19/2021 at 11:16am, Resident #70 complained of pain in the left ankle. Nurse #1 notified Nurse Practitioner #1 (NP). NP gave order for STAT two view x-ray to left ankle. On 5/19/2021 at approx. 12:30pm, Transport Driver #1 provided a return demonstration of how Resident #70 was secured in the wheelchair in the van to Administer and Regional Director of Operations. Transport Driver #1 was able to demonstrate proper use of the four-point wheelchair restraints and chest/lap belt to secure resident. During interview with Transport Driver #1 it was noted that Resident #70 did not have a cushion in his chair and the shower mesh sling had been left under the resident during transport. On 5/19/2021 at 2:02pm x-ray findings showed mildly displaced oblique fracture of the distal diaphysis of the tibia and nondisplaced fracture of the distal fibula. Severe osteopenia noted. Nurse Practitioner #1 gave order to send resident to Emergency Room for evaluation and treatment. 5/19/2021 at approx. 11:00pm Resident #70 returned to the facility with discharge diagnosis of closed left tibial fracture and fracture of the left fibula. Resident #70 is to follow up with CMC Orthopedics Charlotte within one week for reevaluation of leg fracture. Resident #70 was seen at CMC Orthopedics Charlotte on 5/24/2021 to continue with soft cast/splint. 8/2/2021	

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F 689	Continued From page 49 upper body (above the waist) was still in the wheelchair being secured by the chest/lap belt and his legs were noted on the floor of the van. Resident #70 was assisted back into the wheelchair by TD #1 and Nurse Aide (NA) #1 and returned to the facility. Nurse #1 was notified of the incident by TD #1 at approximately 12:30 PM and Resident #70 confirmed to Nurse #1 he had slid out of the wheelchair during transport and denied any pain. Upon nurse assessment, it was noted he had bruises to his legs which were cleaned with wound cleanser and TAO and a dry dressing were applied. On 5/19/21, the Nurse Practitioner (NP) was notified Resident #70 complained of pain in his left ankle and orders were received for a 2-view left ankle x-ray. On 5/19/21 at 11:16 PM, TD #1 provided a return demonstration of how Resident #70 was secured in the wheelchair of the facility van and able to demonstrate proper use of the four-point wheelchair restraints and chest/lap securement system. On 5/19/21 at approximately 2:02 PM, x-ray results were received that confirmed Resident #70 had a mildly displaced oblique fracture of the distal tibia and nondisplaced fracture of the distal fibula. Orders were obtained by the NP to send Resident #70 to the ED for evaluation and treatment and he returned to the facility at 11:00 PM with a cast and orders to follow-up with the Orthopedist within one week. The facility's investigation determined the following root causes: a) Resident #70 was moved after a fall in the facility van without a licensed nurse or medical professional assessment, b) Resident #70 did not have a cushion in his chair and had the mechanical lift sling under him which contributed to him sliding out of the	F 689	CMC orthopedic instructions to continue Fracture Brace everyday to left lower extremity and to follow up in 3-4 months with new x-rays before appointment, appointment may be virtual. The facility failed to ensure proper positioning and securement of Resident #70 while in the transport van to prevent Resident #70 from sliding/falling out of wheelchair during transport. All residents that are transported have the potential to be affected when policies and procedures for proper positioning are not followed. 2. 100% of all drivers' education records were audited on 5/20/2021 and reaudited on 8/6/2021 by the facility Administrator and/or Director of Nursing, to ensure each driver receives necessary education to drive the van safely. All drivers noted to have necessary training and qualification to drive the facility Van to include what to do in-case of an emergency. 100% of residents who has an incident or accident for the last 30 days starting on 4/17/2021 through 5/17/2021 were audited by the facility Director of Nursing on 5/20/2021 to identify any other resident with an incident or accident who was moved without a licensed nurse's assessment and to ensure proper MD and RP notification was completed. No other resident identified to be moved before licensed nurse assessed the resident. Findings of this audit is documented on the incident log audit maintained in the	

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F 689	Continued From page 50 wheelchair of the van, and c) Nurse #1 failed to notify the physician of the incident which resulted in a delay of treatment. During an interview on 08/03/21 at 8:52 AM, Resident #70 recalled he was seated in his wheelchair, headed back to the facility in the transport van, when TD #1 "slammed" on the brakes and he flew forward out of the wheelchair into the dashboard of the van. Resident #70 stated his wheelchair was secure but he did not have a chest or seat belt in place. During a follow-up interview on 08/04/21 at 4:21 PM, Resident #70 clarified when he was seated in the van in his wheelchair, the wheelchair was securely strapped to the floor and now reports he did have the lap/chest belt in place but added the straps were loose and not tight. He stated he was not sure how fast TD #1 was driving but recalled a truck pulled out in front of the van and when TD #1 "slammed" on the brakes he "flew up in the air hitting his knee on the console" that was located in between the driver's seat and the passenger seat. Resident #70 denied hitting his head or chest, just his knee which caused the fracture. When asked how he could have reached the console at the front of the van if the lap/chest belt was fastened, he stated it was loose and "went with him" but never came unfastened. He added the wheelchair then tipped forward to the floor when he landed on the console. When asked how far back he was from the console, he replied 8 to 9 feet and when asked to clarify the distance again, he stated he flew in the air with the lap/chest belt still attached 8 to 9 feet and his knee hit the console. Resident #70 confirmed he did not have a cushion in the seat of his wheelchair prior to or on the day of the	F 689	facility compliance binder. 100% of residents who had an incident or accident for the last 14 days starting on 7/23/2021 through 8/6/2021 were audited by the Regional Clinical Consultant on 8/6/2021 to identify any other resident with an incident or accident who was moved without a licensed nurse's assessment and to ensure proper MD and RP notification was completed. No other resident identified to be moved before licensed nurse assessed the resident. Findings of this audit is documented on the incident log audit maintained in the facility compliance binder. Audit was conducted by Nurse Management to include Director of Nursing, Assistant Director of Nursing, and Unit Managers of all residents that require a mechanical lift transfer to ensure lift slings is removed when transfer is complete. Initial Audit completed on 5/20/2021 and re-audit conducted on 8/6/2021. No issues noted. Regional Plant Operations Manager audited/inspected the Q-straint system that included the floor securements, chest/shoulder and lap belt for proper engagement, securement, and function on 8/9/2021. No issues where noted. 3. Effective 8/6/2021 all non-licensed employees will not move any resident involved in an incident or accident, to include the incidents happened in the facility van when a resident experience any fall until the resident is assessed by	

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F 689	Continued From page 51 incident. During an interview on 08/04/21 at 7:50 AM, TD #1 revealed prior to departure, she made sure Resident #70's wheelchair was secured in the facility van by locking the wheelchair brakes, applying the 4-floor securement locking system to the wheelchair, and attaching the chest/lap belt. TD #1 stated as she was driving down the road, she heard Resident #70 state he was sliding out of the chair, she immediately pulled over to the side of the road and she and NA #1 noticed he had slid down in his wheelchair, with his legs out front and slightly toward the left side and his bottom was still on the edge of the seat with his legs on the floor. She added the chest/lap belt was intact and prevented him from sliding all the way out of the wheelchair. TD #1 recalled Resident #70 had a scratch on the top of his knee that was not bleeding or open and when asked if he was in any pain, he replied 'no.' She added Resident #70 repeatedly asked them to "pull me up" so both she and NA #1 pulled him back up into the wheelchair, checked to make sure all straps were secure and then continued driving back to the facility. Once back at the facility, TD #1 reported the incident to Nurse #1 and Assistant Director of Nursing. TD #1 explained at the time of the incident she wasn't aware that she should not have moved Resident #70 to reposition him back up straight in the wheelchair after the incident but had since received education that prior to moving a resident after an incident or fall, she was to notify the Nurse. During a follow-up interview on 08/05/21 at 8:43 AM, TD #1 explained Resident #70 had no cushion in the seat of his wheelchair but was sitting on a shower lift sling (one with holes to	F 689	the trained personnel. The Facility staff will ensure patient safety is maintained while waiting for help to arrive effective 8/6/2021. Executive Director, and/or Director of Nursing conducted initial education on 5/19/2021-5/20/2021 and re-education began on 8/6/2021 for current staff members to include contract staff. This education included the importance of ensuring resident is not moved from the floor when resident incident or accident occurred until proper assessments are completed by the appropriate, trained personnel (medical provider, licensed nurse and/or emergency medical transport and or paramedic). This education was completed on 8/9/2021, any staff member not educated by 8/9/2021 was no allowed to work until educated on this requirement. Effective 8/10/2021 this education was added to new hires orientation education for all new facility staffs. This education will also be provided annually for all facility staff to include drivers. In-service form stated "The resident should be kept safe in the location observed until help arrived. If a resident fell in an area that put resident at further risk for injuries, extreme precautions must be taken to ensure resident's injuries are not exacerbated, should the resident be moved." Executive Director, and/or Director of Nursing conducted initial education on 5/19/2021-5/20/2021 and re-education began on 8/6/2021 for current drivers and	

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F 689	Continued From page 52 allow water drainage) underneath his bottom and not the normal fabric mechanical lift sling. TD #1 added normally, when using a mechanical lift to assist a resident into the wheelchair, once the resident was seated, they removed the lift sling; however, she was not sure why facility staff had used the shower sling when transferring him to his wheelchair for transport and felt it was left in his wheelchair to assist hospital staff in transferring him during his appointment. TD #1 restated the van's securement floor straps and lap/chest belt were securely attached to Resident #70's wheelchair prior to leaving the hospital and he never slid all the way to the floor from his wheelchair. TD #1 could not explain how Resident #70 was able to slide out of his wheelchair during transport and stated it was possible the hospital staff had not positioned him correctly in the wheelchair after he was examined. She added there was no vehicle that pulled out in front of the van causing her to slam on the brakes and Resident #70 was not thrust forward hitting the console at the front of the van. During interviews on 08/04/21 at 6:55 AM and 6:15 PM, NA #1 confirmed she had gotten Resident #70 ready for his appointment the morning of 5/17/21. NA #1 explained she couldn't find the normal mechanical lift sling to transfer Resident #70 to his wheelchair so she got one of the shower mesh slings from laundry to use instead. She added, normally she would remove the sling once the resident was placed safely in the wheelchair but left it underneath Resident #70 in case the hospital staff needed to use it to transfer him while at his appointment. NA #1 could not recall if Resident #70 had a cushion in the seat of his wheelchair the morning of 05/17/21. NA #1 verified she was present in the	F 689	back up drivers' onsite on 8/6/2021. This education included the importance of ensuring resident is not moved from the floor of the van until proper assessments are completed by the appropriate, trained personnel (medical provider, licensed nurse and/or emergency medical transport, and/or paramedic) This education was completed by 8/9/2021, any driver not educated by 8/9/2021 will not be allowed to drive until educated on this requirement. Effective 8/10/2021 this education was added on new hires orientation education for all new facility drivers. This education will also be provided annually for all facility staff to include drivers. Director of Nursing and/or Assistant Director of Nursing conducted initial education on 5/19/2021 □ 5/20/2021 and re-education began 8/6/2021 with all licensed and non-licensed staff that mechanical lift slings are not be left under a resident after transfer is complete. Licensed and non-licensed staff were also educated on ensuring that resident has cushion in chair. This education was completed by 8/9/2021, any staff member not educated by 8/9/2021 will not be allowed to work until educated on this requirement. Effective 8/10/2021 this education was added on new hires orientation education for all new facility staffs. On 8/9/2021 Regional Plant Operations Manager re-educated all van drivers to ensure wheelchair is secured utilizing the	

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F 689	Continued From page 53 facility transport van with TD #1 and Resident #70 on 05/17/21 when he slid partially out of his wheelchair and confirmed TD #1's statement of what had occurred. She added on the way back to the facility, there was no traffic and no vehicle that pulled out in front of the van causing TD #1 to slam on the brakes nor did Resident #70 fly forward out of his wheelchair from the back of the van and hitting the front console. During a telephone interview on 08/04/21 at 6:23 PM, Nurse #1 stated once Resident #70 returned from his appointment on 05/17/21 she was notified by TD #1 that he had slid partially out of his wheelchair during transport. TD #1 reported to her that Resident #70 was repositioned back up straight in his wheelchair once the van was stopped and she had noticed a small abrasion/scratch on his knee. Nurse #1 stated she immediately completed an assessment which included checking for signs and symptoms of a fracture with no abnormalities noted other than a scratch and some bruising to his right knee which she treated with TAO and applied a dry dressing. She added Resident #70 complained of no pain and when asked what happened he confirmed what TD #1 had reported to her. Nurse #1 added when she provided care to Resident #70 on 05/18/21, he complained of pain and was given Tylenol. She added when she assessed his leg on 05/18/21, there were no signs of obvious fracture and the only injury noted was the scratch and bruising to his knee. On the morning of 05/19/21, Resident #70 complained of increased pain, she notified the NP and an order was obtained for an x-ray. Nurse #1 explained she didn't notify the NP on 05/17/21 because Resident #70 complained of no pain, did not hit his head and upon assessment there was no	F 689	Q-straint system that includes four-point floor wheelchair restraints along with chest/shoulder belt and lap belt. All drivers were required to properly return demonstrate safe accurate securement. Regional Plant Operation Manager utilized Q-straint manufacturer training video as well as a checklist for safe demonstration. Education was completed on 8/9/2021. All facility transports were outsourced until education was completed. Newly hired Transport Drivers will be trained by the Regional Plant Operation Manager going forward. 4. Effective 8/9/2021, Director of Nursing, Assistant Director of Nursing, and/or Staff Development Coordinator, will monitor compliance of staff not moving residents until a proper assessment is completed by a trained licensed employee by conducting clinical meeting daily (Monday through Friday). This meeting will allow the team to review all incidents or accidents that occurred from the prior clinical meeting to ensure that non licensed employee did not move a patient before a proper assessment is completed by the trained personnel. Any issues identified during this monitoring process will be addressed promptly. Findings from this meeting will be documented on a daily clinical report form and filed in the clinical meeting binder after proper follow up is done. Effective 8/9/2021, Director of Nursing and/or Assistant Director of Nursing will complete random audits of total lift	

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F 689	Continued From page 54 signs of a fracture. Nurse #1 stated Resident #70 never mentioned to her at any point the lap/chest belt was loose and he flew forward in the van hitting the console and if he had, she would have immediately notified the Physician or NP. The Nurse Practitioner (NP) progress note dated 05/19/21 read in part, Resident #70 seen for assessment of left leg pain. Per nursing staff, Resident #70 had an appointment on 05/17/21 and upon return to the facility, he slid out of the wheelchair in the facility transportation vehicle. Resident #70 reports he bent his left and right leg underneath the wheelchair at the time of his fall and since then has had increased pain in the left leg. The physical exam noted "internal rotation of the left lower extremity and increased pain on palpation." Orders were given for: Norco (pain medication) 5/325 milligrams every 4 hours as needed for pain, topical antibiotic ointment for the left shin abrasion and transfer to the Emergency Department (ED) for treatment of left tibia-fibula fracture. During interviews on 08/04/21 at 11:30 AM and 3:42 PM, the NP stated she was notified the morning of 05/19/21 that Resident #70 had an accident while being transported in the facility van on 05/17/21 and his leg was injured and painful at which time, she gave orders for pain medication and to obtain an x-ray of his lower leg. The NP stated when she arrived at the facility on 05/19/21 and assessed Resident #70's leg, she noticed it was swollen with bruising to his knee but there were no obvious signs of a fracture such as deformity or protrusion. However, once the results of the x-ray were received it showed a definite fracture and orders were given to send Resident #70 to the ED for evaluation and	F 689	residents to ensure that lift pads are not left under any resident after transfer, ensure proper placement of wheelchair cushion. The audit is to also include residents that are being transported. The monitoring process will be 10 residents per week. Effective 8/9/2021, Administrator or designee will observe all residents being transported to an appointment after being secured by the transport driver to ensure proper securement. Effective 8/9/2021, the Administrator and Director of Nursing will be ultimately responsible to ensure implementation of this immediate jeopardy removal for this alleged noncompliance. Data obtained during the audit process will be analyzed for patterns and trends and reported to Quality Assurance and Performance Improvement (QAPI) by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. Person Responsible: Director of Nursing Date of compliance is 9/20/2021	

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treatment. The NP stated Nurse #1 should have notified her on 5/17/21 when the incident occurred instead of waiting 2 days and while it would not have changed the outcome, it did cause a delay in his treatment. The NP explained had she been informed of the incident on 05/17/21, she would have been able to identify the fracture sooner.

During a telephone interview on 08/10/21 04:30 PM Nurse #2 confirmed she was assigned to provide care to Resident #70 during second shift on 05/17/21, 05/18/21 and 05/19/21. Nurse #2 stated when she reported to work the afternoon of 05/17/21, she was not told of the incident that occurred in the facility transport van and did not find out about the incident until she reported to work the afternoon of 05/18/21. Nurse #2 did not recall observing Resident #70's leg on 05/18/21 or of him complaining of any pain. She explained when he did voice pain, which was usually after therapy, he was provided pain medication that was effective. On 05/19/21 when she reported to work, he was in the process of being sent out to the hospital due to a confirmed leg fracture and when he returned from the hospital that evening, he had cast on his leg.

Results of the mobile x-ray completed at the facility on 05/19/21 noted Resident #70 had a 2-view ankle x-ray which indicated in part, "there is a mildly displaced fracture of the distal tibia and a non-displaced fracture of the distal fibula compatible with fractures of indeterminate (not exactly known) age in the appropriate clinical setting. Severe osteopenia (reduced bone mass) is noted."

During a telephone interview on 08/05/21 at 3:00

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PM, the Radiologist reviewed Resident #70's x-ray result and stated the tibia fracture looked acute (severe and sudden in onset) to him. He explained there was no healing callous (the bony healing tissue which forms around the ends of broken bone) observed on the x-ray which would have typically been noted on the x-ray 2 weeks after a fracture. The fibula fracture was a hairline fracture and hard to see. The Radiologist explained normally, a person would be in a lot of pain with this type of fracture but Resident #70 was not weight bearing.

The Emergency Medical Service Transfer: Emergency Department to Floor Report dated 5/19/21 at 5:06 PM read in part, "reason for visit: fall, leg pain, unspecified fracture of left tibia, initial encounter for closed fracture, unspecified fracture of shaft of left fibula, initial encounter for closed fracture. Pain assessment: patient is not reporting any pain."

The hospital discharge after care notes dated 05/19/21 read in part, "reason for visit - fall, leg pain. Discharge diagnoses were listed as closed left tibial fracture and fracture of left fibula."

During a telephone interview on 08/06/21 at 9:26 AM the Medical Director (MD) did not recall being notified of the incident on 05/17/21 involving Resident #70 but stated the NP was notified and evaluated him on 05/19/21. The MD explained Resident #70's bones were very weak and brittle and simply sliding out of the wheelchair could cause his bones to break.

During an interview on 08/04/21 at 9:07 AM, TD #2 stated he typically transported residents to their appointments in the morning and TD #1 took

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over in the afternoon. TD #2 explained when securing a resident in the facility transport van, he locked the brakes on the resident's wheelchair, secured the wheelchair in place using the 4-point securement floor straps, placed the lap/chest belt across the resident, and then shook the wheelchair side-to-side, which caused the straps to automatically tighten, to ensure the wheelchair was secure. TD #2 confirmed on the morning of 05/17/21, he transported and dropped off Resident #70 and NA #1 at his appointment with no incident. He added, TD #1 picked Resident #70 and NA #1 up later that afternoon to bring them back to the facility.

During an interview, the Administrator recalled on 5/19/21, she was informed Resident #70 was complaining of increased pain after an accident in the facility transport van and an order was received from the NP for a 2-view x-ray. The Administrator immediately went to assess Resident #70 and described his legs as twisted slightly at baseline due to his diagnosis of autoimmune disease. She recalled his left leg was "warm and swollen" and he complained of pain but displayed no obvious signs of fracture. She added, "to be honest, I thought it was cellulitis." She discussed the incident with TD #1 and NA #1 as well as Resident #70 whose details of the event continued to change. She added Resident #70 never stated he had flown forward from the wheelchair into the dashboard and had no injuries to support that statement. After it was determined he did sustain a fracture, she immediately started an investigation which identified the concern that Nurse #1 failed to notify the MD/NP of the incident on the day it occurred. In addition, she indicated they also concluded he was left sitting on the shower mesh

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mechanical lift sling when placed in his wheelchair with no cushion. She explained since the sling used was a slippery material, they felt if there had been a cushion, that she described as made with a rubbery type material, in the seat when he was placed in the wheelchair on the sling, then it wouldn't have been as slick making it less likely for him to slide out of the wheelchair. The Administrator stated a plan of action was developed on 05/19/21 to address the prompt notification of the physician and Responsible Party (RP) of a resident's change in condition and was presented to the Quality Assurance (QA) committee on 05/20/21. She explained the plan of action included: staff education that was provided to all licensed Nurses and Medication Aides related to notifying the physician and RP promptly of any change in condition; audits of clinical documentation and incident/accident reports to ensure notifications were completed timely; and monitoring systems put into place to ensure continued compliance that were still ongoing. The Administrator stated they never considered the possibility the chest/lap belt was not properly secured at the time of the incident since both TD #1 and NA #1 confirmed it was intact; therefore, the possibility Resident #70 was not secure at the time of the incident was not considered a factor when trying to determine a possible root cause. The Administrator confirmed they were unable to determine what actually occurred to cause Resident #70 to slip out of the wheelchair and stated she felt it was an unfortunate, "freak" accident.

A telephone interview with a Representative of the manufacturer of the wheelchair safety securement system utilized by the facility was conducted on 08/06/21 at 3:36 PM. The

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Representative stated they recommended using the chest/lap belt when transporting a resident in the transport van by placing the lap belt underneath the arm rest and across the lap tightly to prevent someone from sliding out of the wheelchair. The Representative added if the lap/chest belt was properly applied and secured according to the manufacturer's instructions, then Resident #70 should not have been able to slide out of the wheelchair during transport.

An observation of a shower mesh mechanical lift sling that was used to transfer Resident #70 was conducted with the Administrator on 08/04/21 at 4:29 PM. The base and sides of the sling were a slippery, mesh material with fabric straps on each end that attached to the mechanical lift when used for transfers.

An observation of the facility transport van and follow-up interview was conducted on 08/05/21 with TD #1. Surveyor #1 was seated in the transport wheelchair used to transport Resident #70 to his appointment on 05/17/21. TD #1 locked the brakes of the wheelchair, attached the 4-floor securement hooks onto the wheelchair and checked to make sure the locking system was secure. TD #1 then attached the chest/lap belt and checked for securement. The wheelchair was placed in the middle just behind the driver and passenger seats. When the wheelchair was shaken side-to-side, the floor straps and locks remained secure. When leaning forward from a sitting position, the lap belt tightened while the chest/shoulder strap gave approximately 12 inches allowing the upper body to lean forward before tightening and preventing a fall out of the wheelchair. During the observation, TD #1 described Resident #70 was seated in the

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wheelchair leaning slightly toward the right side with his legs angled toward the left, in between the footrests of the wheelchair. TD #1 explained when Resident #70 slid out of the wheelchair during transport and she stopped the van, his right knee landed on the floor of the van and his lower left and right legs were on the floor underneath the left footrest of the wheelchair. She restated the lap/chest belt remained in a locked position but his lower body had slid down from under the lap belt allowing his knee to hit the floor while his bottom had remained resting on the edge of the seat.

The Administrator and Regional Clinical Consultant were notified of Immediate Jeopardy on 08/06/21 at 2:06 PM. The facility provided the following Credible Allegation of Immediate Jeopardy Removal:

1) Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:

On 5/17/2021 at approx. 11:30am, Resident #70 was being transported in the facility's van back to the facility following an appointment accompanied by Transport Driver #1 and Nurse Aide #1. During transport, Resident #70 informed Transport Driver #1 he was sliding out of his wheelchair. Transport Driver #1 immediately pulled the van over to the side of the road and both she and Nurse Aide #1 noted Resident #70 had slid down, but he was not completely out of his wheelchair. Transport Driver #1 reported that Resident #70 had his upper body (above the waist) was still in the wheelchair, being secured by the chest/lap belt. Per Transport Driver #1 Resident #70 right knee was on the floor of the

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van and his left leg was on the floor and underneath the footrest of the wheelchair. Transport Driver #1 and Nurse Aide #1 assisted Resident #70 back into wheelchair, making sure that his seat/lap belt and wheelchair were all secure and continued back to the facility. At approx. 12:30, Transport Driver #1 arrived back to the facility with Resident #70. Transport Driver #1 notified Nurse #1 of Resident #70 sliding out of the wheelchair. In a nursing note by Nurse #1 on 5/17/2021 at 4:02pm read in part that Resident #70 returned from appointment with no new orders. Transport Driver #1 reported that Resident #70 slid out of wheelchair and had bruises to his leg. Resident #70 confirmed incident. Bruises on left leg cleaned with wound cleanser and covered with TAO and dry dressing, treatment provided by Nurse #1. Nurse #1 noted resident denied pain. Responsible Party contacted, no answer, nurse monitoring. Incident report, fall and pain assessment completed by Nurse #1. Nurse #1 reported that she completed an assessment which included checking for sign/symptoms of a fracture with no abnormalities noted other than the scratch and bruising to his left leg in which she treated with the TAO and a dressing.

On 5/18/2021 at 2:24 AM Nurse #2 noted resident status post fall with bruise to left leg with no complaints of pain and no acute distress.

On 5/18/2021 Nurse #1 reported during her shift (1st) that resident #70 complained of pain to left leg and was given Tylenol that she reported was effective, she also reported she assessed Resident #70 leg and there were no signs of obvious fracture and the only injury noted was the scratch and bruise to his left leg.

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On 5/19/2021 at 9:44 am Nurse #2 noted bruising to left leg persist no complaints of pain or discomfort.

On 5/19/2021 at 11:16am, Resident #70 complained of pain in the left ankle. Nurse #1 notified Nurse Practitioner #1 (NP). NP gave order for STAT two view x-ray to left ankle.

On 5/19/2021 at approx. 12:30pm, Transport Driver #1 provided a return demonstration of how Resident #70 was secured in the wheelchair in the van to Administer and Regional Director of Operations. Transport Driver #1 was able to demonstrate proper use of the four-point wheelchair restraints and chest/lap belt to secure resident. During interview with Transport Driver #1 it was noted that Resident #70 did not have a cushion in his chair and the shower mesh sling had been left under the resident during transport.

On 5/19/2021 at 2:02pm x-ray findings showed mildly displaced oblique fracture of the distal diaphysis of the tibia and nondisplaced fracture of the distal fibula. Severe osteopenia noted. Nurse Practitioner #1 gave order to send resident to Emergency Room for evaluation and treatment.

5/19/2021 at approx. 11:00pm Resident #70 returned to the facility with discharge diagnosis of closed left tibial fracture and fracture of the left fibula. Resident #70 is to follow up with CMC Orthopedics Charlotte within one week for reevaluation of leg fracture. Resident #70 was seen at CMC Orthopedics Charlotte on 5/24/2021 to continue with soft cast/splint. 8/2/2021 CMC orthopedic instructions to continue Fracture Brace every day to left lower extremity and to follow up

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in 3-4 months with new x-rays before appointment, appointment may be virtual.

The facility failed to ensure proper positioning and securement of Resident #70 while in the transport van to prevent Resident #70 from sliding/falling out of wheelchair during transport.

All residents that are transported have the potential to be affected when policies and procedures for proper positioning are not followed.

2) Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:

100% of all drivers' education records were audited on 5/20/2021 and reaudited on 8/6/2021 by the facility Administrator and/or Director of Nursing, to ensure each driver receives necessary education to drive the van safely. All drivers noted to have necessary training and qualification to drive the facility Van to include what to do in-case of an emergency.

100% of residents who has an incident or accident for the last 30 days starting on 4/17/2021 through 5/17/2021 were audited by the facility Director of Nursing on 5/20/2021 to identify any other resident with an incident or accident who was moved without a licensed nurse's assessment and to ensure proper MD and RP notification was completed. No other resident identified to be moved before licensed nurse assessed the resident. Findings of this audit is documented on the incident log audit maintained in the facility compliance binder.

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F 689	Continued From page 64 100% of residents who had an incident or accident for the last 14 days starting on 7/23/2021 through 8/6/2021 were audited by the Regional Clinical Consultant on 8/6/2021 to identify any other resident with an incident or accident who was moved without a licensed nurse's assessment and to ensure proper MD and RP notification was completed. No other resident identified to be moved before licensed nurse assessed the resident. Findings of this audit is documented on the incident log audit maintained in the facility compliance binder. Audit was conducted by Nurse Management to include Director of Nursing, Assistant Director of Nursing, and Unit Managers of all residents that require a mechanical lift transfer to ensure lift slings is removed when transfer is complete. Initial Audit completed on 5/20/2021 and re-audit conducted on 8/6/2021. No issues noted. Regional Plant Operations Manager will audit/inspect the Q-straint system to include floor securements, chest/ shoulder and lap belt for proper engagement, securement, and function on 8/9/2021. Any identified issues will be corrected. Effective 8/6/2021 all non-licensed employees will not move any resident involved in an incident or accident, to include the incidents happened in the facility van when a resident experience any fall until the resident is assessed by the trained personnel. The Facility staff will ensure patient safety is maintained while waiting for help to arrive effective 8/6/2021. Executive Director, and/or Director of Nursing conducted initial education on	F 689		

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SATURN NURSING AND REHABILITATION CENTER	1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262

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5/19/2021-5/20/2021 and re-education began on 8/6/2021 for current staff members to include contract staff. This education included the importance of ensuring resident is not moved from the floor when resident incident or accident occurred until proper assessments are completed by the appropriate, trained personnel (medical provider, licensed nurse and/or emergency medical transport and or paramedic). This education will be completed by 8/9/2021, any staff member not educated by 8/9/2021 will not be allowed to work until educated on this requirement. This education will be added on new hires orientation education for all new facility staffs. This education will also be provided annually for all facility staff to include drivers. In-service form stated "The resident should be kept safe in the location observed until help arrived. If a resident fell in an area that put resident at further risk for injuries, extreme precautions must be taken to ensure resident's injuries are not exacerbated, should the resident be moved."

Executive Director, and/or Director of Nursing conducted initial education on 5/19/2021-5/20/2021 and re-education began on 8/6/2021 for current drivers and back up drivers' onsite on 8/6/2021. This education included the importance of ensuring resident is not moved from the floor of the van until proper assessments are completed by the appropriate, trained personnel (medical provider, licensed nurse and/or emergency medical transport, and/or paramedic) This education was completed by 8/9/2021, any driver not educated by 8/9/2021 will not be allowed to drive until educated on this requirement. This education will be added on new hires orientation education for all new facility

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drivers. This education will also be provided annually for all facility staff to include drivers.

Director of Nursing and/or Assistant Director of Nursing conducted initial education on 5/19/2021 - 5/20/2021 and re-education began 8/6/2021 with all licensed and non-licensed staff that mechanical lift slings are not be left under a resident after transfer is complete. Licensed and non-licensed staff were also educated on ensuring that resident has cushion in chair. This education will be completed by 8/9/2021, any staff member not educated by 8/9/2021 will not be allowed to work until educated on this requirement. This education will be added on new hires orientation education for all new facility staffs.

Regional Plant Operations Manager will re-educate all van drivers to ensure wheelchair is secured utilizing the Q-straint system that includes four-point floor wheelchair restraints along with chest/shoulder belt and lap belt. All drivers will be required to properly return demonstrate safe accurate securement. Regional Plant Operation Manager will utilize Q-straint manufacturer training video as well as a checklist for safe demonstration. Education to be completed by 8/9/2021. All facility transports will be outsourced until education is completed. Newly hired Transport Drivers will be trained by the Regional Plant Operation Manager going forward.

Effective 8/9/2021, Director of Nursing, Assistant Director of Nursing, and/or Staff Development Coordinator, will monitor compliance of staff not moving residents until a proper assessment is completed by a trained licensed employee by

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conducting clinical meeting daily (Monday through Friday). This meeting will allow the team to review all incidents or accidents that occurred from the prior clinical meeting to ensure that non licensed employee did not move a patient before a proper assessment is completed by the trained personnel. Any issues identified during this monitoring process will be addressed promptly. Findings from this meeting will be documented on a daily clinical report form and filed in the clinical meeting binder after proper follow up is done.

Effective 8/9/2021, Director of Nursing and/or Assistant Director of Nursing will complete random audits of total lift residents to ensure that lift pads are not left under any resident after transfer, ensure proper placement of wheelchair cushion. The audit is to also include residents that are being transported. The monitoring process will be 10 residents per week.

Effective 8/9/2021, Administrator or designee will observe all residents being transported to an appointment after being secured by the transport driver to ensure proper securement.

Effective 8/9/2021, the Administrator and Director of Nursing will be ultimately responsible to ensure implementation of this immediate jeopardy removal for this alleged noncompliance.

The facility alleged immediate jeopardy removal effective date 8/10/2021.

On 08/13/2021, the facility's credible allegation for Immediate Jeopardy removal effective 08/10/21 was validated by the following: the manufacturer's video for the 4-point wheelchair

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F 689	Continued From page 68 securement system utilized by the facility was reviewed regarding manufacture instructions on how to secure a resident for transport in a van. Transportation drivers were observed providing a return demonstration on securing a resident per manufacturer guidance. Staff interviews revealed receipt of education regarding how to load/unload a resident onto a van for transport, how to secure the wheelchair for transport using the 4-point wheelchair securement system, how to strap a resident in the wheelchair using a lap/chest seat belt, how to lock wheelchair brakes and check the wheelchair and resident for securement prior to transport. Staff interviews also revealed staff education was received regarding not to move a resident after an accident, but to allow emergency services or a nurse to assess the resident prior to the resident being moved. The facility implemented audit tools to monitor residents for safe transport, call emergency services in the event of an emergency and notify the facility administrator and nurse for any resident who was involved in an accident during transport for nursing assessment.	F 689		
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	F 692		9/20/21

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F 692	Continued From page 69 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 observation, staff interviews and record review, the facility failed to provide large portions of food as ordered by the physician to 1 of 6 sampled residents at risk for weight loss (Resident #98). The findings included: Resident #98 was admitted to the facility on 10/7/20. Diagnoses included constipation and anemia, among others. Medical record review revealed a physician order dated 10/21/20 for a regular diet with large portions at all meals due to a history of weight loss. A progress note written by the consultant Registered Dietitian (RD) dated 4/7/21 recorded in part that Resident #98 was referred due to poor food intake with an intake range of 25 - 100%. His physician prescribed diet was a regular diet with large portions. The RD recommended a nutritional supplement for weight gain. A quarterly Minimum Data Set Assessment, dated 7/10/21, assessed Resident #98 as dependent on	F 692	1. Facility failed to provide large portions of food as ordered by the physician for residents at risk for weight loss for Resident # 98. Resident #98 portion size was corrected immediately. 2. An audit will be conducted by 9/20/2021 by Registered Dietary Manager of all residents with physician orders to ensure that they received large portions on tray. 3. Executive Director will educate dietary staff on large portions, filling utensils correctly, and use of appropriate measuring utensils to ensure proper portion size for large portions (regular portion per recipe and an addition of a half portion). Education will be added to dietary orientation. Education completed by 9/20/2021. Certified Dietary Manager or designee will audit trays for proper large portions 15 trays per week x 4 weeks, 10 trays per week x 4 weeks, then 5 trays per week x 4 weeks.	

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F 692	Continued From page 70 staff for feeding assistance during meals and he weighed 142 pounds with no current weight loss. A care plan revised July 2021, recorded Resident #98 was at nutritional risk due to a history of weight loss and received a regular diet with large portions at all meals. The goal included some gradual weight gain; interventions included to monitor intake daily. During a continuous observation of the lunch meal tray line on 8/3/21 from 11:45 AM - 11:53 AM, the Assistant Dietary Manager (ADM) was observed to plate spinach and diced red skin potatoes using a one-half cup serving utensil for each with the following concerns noted: ·The ADM did not fill the one-half cup serving utensil when plating the spinach, but rather filled the utensil approximately ¾ full, then filled the half cup serving utensil ¼ full, for a total serving of one-half cup. ·The ADM was observed to plate one-half cup of diced red skin potatoes for Resident #98. ·Resident #98 did not receive a large portion of spinach or diced red skin potatoes. Review of the menu revealed a regular portion of spinach was one-half cup and a regular portion of diced red skin potatoes was one-half cup. The menu did not specify the portion of spinach or potatoes to be served to a resident with a diet order for large portions. During an interview on 8/3/21 at 12:03 PM, the Certified Dietary Manager (CDM) stated that when the ADM was hired two weeks ago, she	F 692	4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Executive Director monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. Date of Compliance is 9/20/2021 5. Person Responsible: Executive Director	

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F 692	Continued From page 71	F 692		

stated, "I don't cook", and so far, she had only received a couple days of training with two of the cooks. He stated that the Assistant Dietary Manager (ADM) had not yet trained with him. The CDM further stated that he informed the ADM that day (8/3/21) that she would need to have more days for training. The CDM further stated that he worked as the evening cook the day before, and therefore he was not in the kitchen to provide oversight for the lunch meal that day (8/3/21). He stated the ADM was filling in because the regular cook was off. The CDM stated that the facility did not have a written policy regarding large portions, but that the cooks were trained to serve one and one-half portion of a regular menu portion to residents with diet orders for large portions. He stated that the incorrect portion of spinach and potatoes served was an oversight and that Resident #98 should have received three fourths cup or six-ounce portion of spinach and red skin potatoes.

An interview with the ADM occurred on 8/03/21 at 2:02 PM. The ADM stated that she was hired in her role three weeks ago and had only observed the CDM and one of the cooks a few times but that she had not received formal training in this role. The ADM stated in her previous responsibilities as a dietary supervisor, she did not cook, so since she assumed her role as ADM, she had to ask questions about providing the correct portions because she had not been trained. The ADM further stated that she served what she thought was a large portion, but that she was unaware that she did not provide the correct portion of food for a large portion of spinach and potatoes. She further stated it was an oversight because she had not been trained.

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F 692	Continued From page 72 The Administrator was interviewed on 8/04/21 at 12:29 PM and stated that she expected dietary staff to serve residents foods in the portion according to their diet order. The Administrator further stated the facility did not have a written policy on providing residents with large portions, but that dietary staff were trained to provide a resident with a diet order for large portions a regular portion and a half. A telephone interview occurred with the RD on 8/04/21 at 3:18 PM. The RD stated that she rounded at the facility every other week, reviewed/approved menus, and conducted monthly kitchen inspections. The RD further stated that she was not aware of dietary concerns related to staff serving incorrect portions, but that residents with a diet order for large portions should receive a regular portion and a half of each food item unless otherwise indicated.	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to keep the water collection device for the tracheostomy collar tubing off the floor, failed to perform hand hygiene before and after	F 695	1. Facility failed to keep the water collection device for the tracheostomy collar tubing off the floor failed to perform hand hygiene before and after suctioning	9/20/21

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F 695	Continued From page 73 suctioning a tracheostomy, and failed to maintain sterile technique when suctioning a tracheostomy for 1 of 1 resident (Resident #44) reviewed for tracheostomy care. Findings included: 1a. Resident #44 was admitted to the facility 01/22/21 with diagnoses including respiratory failure and anxiety. A review of the quarterly Minimum Data Set (MDS) dated 05/10/21 revealed Resident #44 was severely cognitively impaired and received tracheostomy care. Review of the care plan for tracheostomy care last updated 05/04/21 revealed the care plan goal was for Resident #44 to be free from infection/complications related to his tracheostomy. Interventions included suctioning as needed/per orders and monitoring tracheostomy site and secretions for signs or symptoms of infection. An observation of the water collection device for Resident #44's tracheostomy collar tubing on 08/01/21 at 12:41 PM revealed the water collection device was resting on the floor. An observation of the water collection device for Resident #44's tracheostomy collar tubing on 08/02/21 at 02:08 PM revealed the water collection device was resting on the floor. An observation of the water collection device for Resident #44's tracheostomy collar tubing on 08/03/21 at 09:04 AM revealed the water collection device was resting on the floor.	F 695	a tracheostomy and failed to maintain sterile technique when suctioning tracheostomy for Resident #44. A clip was added to the tubing to help aid the collection bag from touching the floor and Unit Manager #1 was provided education regarding hand hygiene and sterile technique with return demonstration. Nurse #9 is no longer employed at the facility. 2. An audit was conducted by the Director of Nursing of all residents with tracheostomies to ensure they have a clip to their water collection device on collar tubing. Audit completed on 8/4/2021. 3. Director of Nursing and Assistant Director of Nursing to educate all Licensed Nurses on hand hygiene and sterile technique for suctioning of a tracheostomy. Education will be added to New Hire Orientation. Education to be completed by 9/20/2021. Director of Nursing and Assistant Director of Nursing to educate all Licensed Nurses, Certified Nursing Aids, and Nurse Aids in Training on keep water collection devices for trach collar tubing off the floor. Education to be added to New Hire Orientation. Education to be completed by 9/20/2021. Director of Nursing or designee will observe resident trach suctioning 5x per week for 4 weeks, 3x per week for 4 weeks, then 1x per week for 4 weeks to ensure proper hand hygiene and sterile technique is maintained as well as	

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F 695	Continued From page 74 An interview with the House Supervisor on 08/03/21 at 11:30 AM revealed the water collection device for Resident #44's tracheostomy collar tubing should not be on the floor. He stated when staff were in Resident #44's room they should make sure the water collection device for his tracheostomy collar tubing was not on the floor and if it was observed to be on the floor then it should be adjusted so it did not rest on the floor. An observation of the water collection device for Resident #44's tracheostomy collar tubing on 08/03/21 at 03:57 PM revealed the water collection device was resting on the floor. An observation of the water collection device for Resident #44's tracheostomy collar tubing on 08/04/21 at 07:15 AM revealed the water collection device was resting on the floor. An interview with the Director of Nursing (DON) on 08/04/21 at 08:42 AM revealed the nurse caring for Resident #44 should be keeping the water collection device for his tracheostomy collar emptied as needed and making sure the water collection device does not rest on the floor. She stated if the water collection device was resting on the floor it should be adjusted so it was not touching the floor. An interview with the Administrator on 08/05/21 at 06:15 AM revealed Resident #44's water collection device for his tracheostomy collar tubing should not be resting on the floor and nursing staff should be monitoring the tubing periodically to make sure it was not touching the floor.	F 695	monitor for water collection device is not touching the floor during observations. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Person Responsible: Director of Nursing Date of compliance is 9/20/2021	

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b. Review of the facility's policy titled Procedure: Tracheal Suctioning-Open Suctioning System last updated in 2019 read in part: "perform hand hygiene according to facility policy/protocol, open suction kit, put on sterile gloves and remove the catheter (tube) from kit, attach catheter to suction source (the hand touching suction tubing is no longer sterile), apply suction and withdraw catheter in a rotating/twisting manner, discard catheter and gloves, and perform hand hygiene according to facility policy/protocol".

Resident #44 was admitted to the facility 01/22/21 with diagnoses including respiratory failure and anxiety.

A review of the quarterly Minimum Data Set (MDS) dated 05/10/21 revealed Resident #44 was severely cognitively impaired and received tracheostomy care.

Review of the care plan for tracheostomy care last updated 05/04/21 revealed the care plan goal was for Resident #44 to be free from infection/complications related to his tracheostomy. Interventions included suctioning as needed/per orders and monitoring tracheostomy site and secretions for signs or symptoms of infection.

An observation of Unit Manager #1 on 08/01/21 at 12:41 PM revealed she was feeding Resident #44 his lunch. Resident #44 told Unit Manager #1 he needed to be suctioned. Unit Manager #1 left Resident #44's room to gather suctioning supplies and returned to the room. Unit Manager #1 closed the door, applied clean gloves, opened the package of sterile gloves and removed her clean gloves. The package of sterile gloves only

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contained 1 sterile glove and Unit Manager #1 put on the 1 sterile glove on her right hand, opened the door with her ungloved left hand, had a staff member place a clean glove on her left hand, closed the door, and began suctioning Resident #44 with her right hand. When Unit Manager #1 finished suctioning Resident #44 she removed her gloves and returned to feeding Resident #44.

An interview with Unit Manager #1 on 08/01/21 at 03:07 PM revealed she should have performed hand hygiene before and after suctioning Resident #44 and she should have maintained sterile technique while suctioning Resident #44. She stated she should have gotten a new pack of sterile gloves that contained 2 sterile gloves before suctioning Resident #44. Unit Manager #1 stated not performing hand hygiene and ensuring she had the correct gloves on were oversights.

An interview with the Administrator on 08/05/21 revealed hand hygiene should have been performed before and after suctioning Resident #44 and sterile technique should have been used while suctioning.

c. An observation of Nurse #9 on 08/02/21 at 03:10 PM revealed she had been performing wound care for Resident #44. Resident #44 told her he needed to be suctioned. Nurse #9 removed her clean gloves, did not perform hand hygiene, applied sterile gloves, threw the glove wrapper away, unwrapped the sterile suction catheter, turned on the suction machine, removed Resident #44's passy miur valve (a valve that allows for verbal communication when placed on the hub of a tracheostomy tube), allowed the sterile suction catheter to touch Resident #44's beard, suctioned Resident #44, replaced the

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F 695	Continued From page 77 passy muir valve, and removed gloves. Nurse #9 began getting materials ready for an additional dressing change without performing hand hygiene after suctioning. An interview with Nurse #9 on 08/02/21 at 03:56 PM revealed she should have performed hand hygiene before and after suctioning Resident #44 and she did not because it was an oversight. Nurse #9 also stated tracheostomy suctioning was a sterile procedure and she should have used sterile technique. She also explained she did not see the sterile suction catheter touch Resident #44's beard before he was suctioned. An interview with the Administrator on 08/05/21 revealed hand hygiene should have been performed before and after suctioning Resident #44 and sterile technique should have been used while suctioning.	F 695		
F 697 SS=H	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident, staff and Medical Doctor (MD) interviews, the facility failed to manage and treat complaints of pain for 1 of 1 resident (Residents #410) reviewed for pain. The facility failed to manage Resident #410's pain during surgical wound dressing changes which resulted in the resident	F 697	1. Facility failed to manage and treat complaints of pain for Resident #410. Facility failed to manage Resident #410□s pain during surgical wound dressing changes which resulted in the resident experiencing severe pain. Facility in addition failed to administer pain	9/20/21

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F 697	Continued From page 78 experiencing severe pain. The facility also failed to administer pain medication to Resident #410 during dressing changes as per the physician order. The findings included: Resident #410 was admitted to the facility from a hospital on 07/20/21 with a diagnosis of necrotizing (death of tissue) soft tissue infection of the sacrum. Review of the baseline care plan dated 07/20/21 revealed Resident #410 had a surgical wound to his mid buttocks. The care plan goal was for Resident # 410's wound to heal and return home. Treatments included the wound to be packed and a fresh dressing applied two times a day. Review of Resident #410's admission Minimum Data Set, dated 07/30/21 revealed Resident #410 was cognitively intact and had a surgical wound. The MD's order dated 07/20/21 revealed the following order for wound care: "Dakin's 0.25% solution (a solution used to kill germs and prevent germ growth in wounds) soaked gauzes were to be applied to the buttocks wound and covered with dry gauze and abdominal pads (which are non-adherent) secured with tape twice a day." Resident #410's physician progress note dated 07/22/21 revealed Resident #410 was admitted for wound care and dressing changes twice a day and will monitor and assist with pain management. Review of a NP progress note dated 07/23/21 revealed "Reports his pain is increasing daily with	F 697	medication to Resident #410 during dressing change as per the physician order. Medical Director was contacted on 8/2/2021 to assess resident□s pain and Medical Director restarted Resident□s Dilaudid 4mg with dressing changes. 2. An Audit was conducted by Nurse Management (Director and Assistant Director of Nursing, Unit Mangers, and Wound nurse of all residents with wound treatments to ensure adequate pain control. Any identified issues to be corrected. Audit will be completed by 9/20/2021. 3. Director of Nursing and Assistant Director of Nursing to educate all Licensed Nurses on pain management, signs, and symptoms of pain both verbal and non-verbal. Education will be added to New Hire Orientation. Education to be completed by 9/20/2021. Director of Nursing or designee will observe residents receiving wound dressing changes 5x per week for 4 weeks, 3x per week for 4 weeks, then 1x per week for 4 weeks to ensure adequate pain control is maintained. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued	

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dressing changes and rates his pain a 10/10. He reports with the medication his dressing changes puts his pain at 5-6/10."

In a NP progress note dated 7/27/21, the NP documented that Resident #410 has been started on Dilaudid 4 mg 30 minutes prior to dressing change and his pain as been controlled. She documented "per nursing resident did not exhibit increased pain response with wound care prior to his initiation on Dilaudid for his pain and he tolerated dressing change without Dilaudid dose." She noted she would discontinue the Dilaudid.

Record review of progress note dated 08/02/21 written by the physician stated, "Patient states the pain medication he is receiving inadequate to control his discomfort, stated he was receiving Dilaudid 2 mg prior to dressing change which is a decrease in the dosage first ordered and requesting to have medication returned to 4 mg Dilaudid before dressing change." He documented he will reinitiate his pain medication.

Review of Resident #410's pain medication orders revealed the following:

7/20/21 - Acetaminophen 325 mg tablet give one tablet by mouth every six hours for pain

7/20/21 - Hydrocodone - Acetaminophen 5-325 mg, one tab every 6 hours for moderate pain as needed.

7/23/21 - Dilaudid 4 mg tablet take 1 tablet daily before dressing changes.

7/24/21 - Discontinued Hydrocodone - Acetaminophen 5-325 mg, one tab every 6 hours

auditing is necessary to maintain compliance. Date of compliance is 9/20/2021
5. Person Responsible: Director of Nursing

Date of compliance is 9/20/2021

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for moderate pain
as needed.

07/26/21 - Hydrocodone - Acetaminophen 5-325 mg take one tablet by mouth every 6 hours as needed for
pain

7/27/21 - Discontinue Dilaudid 4 mg by Nurse Practioner (NP).

8/02/21 - Dilaudid 4 mg tablet give one tablet by mouth 30 minutes before dressing changes
for pain

8/03/21 - Dilaudid 4 mg tablet give one tablet for one time by mouth before dressing
change. Do not give any more for today 8/3/2021.

8/05/21 - Discontinued Acetaminophen 325 mg tablet give one tablet by mouth every six
hours for pain

08/05/21 - Acetaminophen 325 mg tablet take 1 tablet by mouth every 6 hours for
pain (re-ordered)

8/06/21 - Dilaudid 4 mg tablet take one tablet by mouth one time for dressing change

8/06/21 - Discontinue Dilaudid 4 mg.

8/06/21 - Dilaudid 4 mg tablet take one tablet by mouth one time for dressing change -
(second order for this med on 8/6/21).

8/06/21 - Dilaudid discontinued.

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F 697	Continued From page 81 A. 7/23/21 - 7/26/21: Per the Treatment Administration Record (TAR), Resident #410 had 8 dressing changes and per the Medication Administration record (MAR) he was medicated 4 times with dressing changes. B. 7/27/21 - 8/1/21 - Per the TAR Resident #410 had 12 dressing changes and per MD orders no Diaudid ordered for dressing changes. Hydrocodone - Acetaminophen 5-325 mg was available for pain. C. 8/2/21 - 8/9/21 - Per the TAR Resident #410 had 16 dressing changes and per the MAR he was medicated 8 times with dressing changes. An observation of wound care on Resident #410 on 08/3/21 at 11:30 AM by a Wound Nurse # 2 revealed that resident #410 was medicated with Dilaudid 4 milligrams (mg) at 10:46 AM. The resident flinched in pain a few times while the packing was being replaced but said he was okay to continue. He stated the Dilaudid made all the difference. He stated the wound felt so much better when the dressing was fresh, but towards the 10-12 hour mark the dressing dried out and started to hurt. In an interview on 08/01/21 at 3:15 PM with Resident #410 he stated the packing and dressing change of his wound was very painful.	F 697		

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He stated he saw the NP today and told her the current medication of Hydrocodone Acetaminophen 5-325 mg one tablet every 6 hours as needed was not strong enough for his pain during wound care. He stated on 07/23/21 he was ordered 4 mg of Dilaudid (an opioid pain medication), one tablet before wound care and it made a significant difference in his pain. Resident # 410 stated his pain level without the Dilaudid during wound care was 9-10 out of 10. He stated he would clench his fists; his body would be very tense, and he would be tearful. He stated his pain level during wound care with Dilaudid was 5-6 out of 10 and manageable. He stated things were going alright until the NP discontinued the Dilaudid on 07/27/21.

In an interview with Resident #410's MD on 08/02/21 at 8:50 AM revealed he was not aware Resident #410 had any concerns with his dressings changes. He stated he was unaware the order for Dilaudid before wound care had been discontinued, and that Resident #410 had complained about severe pain with wound care without the medication. The physician stated he would talk with Resident #410 and the NP.

In an interview on 08/03/21 at 10:16 AM with the NP revealed that Wound Nurse #1 told her she forgot to give Resident #410 his Dilaudid before his wound care on 07/26/21 and she felt he tolerated the dressing change well without pain medication. The NP stated she then decided to discontinue the Dilaudid.

In an interview with Resident #410 on 08/04/21at 9:40 AM he stated he asked the NP why he wasn't getting Dilaudid for dressing changes. She stated that Wound Nurse #1 had told her he

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was not having pain during dressing changes. Resident #410 stated he told her he was surprised by that because when his dressing changes were done without Dilaudid his pain level was nine-ten out of ten, and with Dilaudid his pain was a five-six out of 10 and manageable. He stated every day after the Dilaudid was discontinued he told every wound nurse how much pain he was in during dressing changes.

On 08/04/21 at 12:53 PM a phone interview was conducted with Wound Nurse #1 who stated initially Resident #410 did not mention pain with his wound care, but on 07/26/21 halfway through the wound care he told her he needed the Dilaudid before he got his dressing changed. She stated she did not know anything about that order. Resident #410 told Wound Nurse #1 the order for Dilaudid was written on 7/23/21. She stated she asked another nurse about the order, she didn't know her name, and the nurse pulled up the order in the computer so Wound Nurse #1 could verify. Wound Nurse #1 stated she discussed the order with the NP and told the NP he exhibited no signs of pain during wound care, and since his admission she had seen him up walking, sitting outside and smoking so he seemed to be fine

An interview conducted on 08/05/21 at 2:10 PM with the Administrator revealed it was her expectation for physician pain medication orders to be followed as written. She stated she had seen the wound and knew it was bad.

In a telephone interview with Nurse #3 on 08/06/21 at 06:06 PM she stated she performed wound care on several occasions and the wound was "massive, so wide and deep." The first day

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F 697	Continued From page 84 she changed the wound the Dilaudid had not been ordered and he experienced a lot of pain. Once the Dilaudid was ordered and she could pre-medicate him she saw a big difference with his pain being decreased. She stated "the dressing change was a very painful procedure and those nerve endings were not dead."	F 697		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced	F 725		9/20/21

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by:
Based on observations, record reviews and resident and staff interviews, the facility failed to maintain sufficient nursing staff to ensure dependent residents received incontinence care as needed for 1 of 7 sampled residents (Resident #77).

Findings included:

This tag is cross-referenced to:

F-677: Based on observations, record review, and staff interviews, the facility failed to check for incontinence or provide incontinence care to a resident for 1 of 7 sampled residents dependent on staff for activities of daily living (Resident #77).

During an interview on 08/02/21 at 9:00 AM, Nurse #6 stated she typically worked weekends 7:00 PM to 7:00 AM and staffing was usually short with only 2 Nurses and 3 Nurse Aides (NA). Nurse #6 explained it was normal for her to report to work and find residents that were left wet or soiled from the previous shift. She stated when she noticed a resident hadn't been changed, it was usually during medication pass so she would inform the NA and they would provide care as soon as they could. Nurse #6 added there would be times residents wouldn't be changed for a couple of hours at a time.

During an interview on 08/03/21 at 11:33 AM, the Nursing House Supervisor (NHS) stated he started his employment approximately one week ago and during that time, staffing was an issue. The NHS added he had frequently been pulled to cover a medication cart due to the staff shortage. He stated the staff were overworked and doing

1. Facility failed to provide sufficient nursing staff to ensure dependent residents received incontinence care for Resident #77 on 8/1/2021. Resident #77 was provided incontinent care on 8/1/2021 by NA #9.

2. An audit will be conducted by the Executive Director of the last 14 days to ensure staffing was adequate for resident census. This audit will be completed by 9/20/2021. Executive Director, Director of Nursing, Assistant Director of Nursing, Unit Coordinators and the Social Worker will interview all alert and oriented residents to ensure timely incontinence care is being provided. This audit will be completed by 9/20/2021.

3. Executive Director to educate Director of Nursing and Scheduling Coordinator on the requirement to properly staff the facility based up on facility census. This education will be added to new hire packet. This education to be completed by 9/20/2021.

Executive Director and/or Director of Nursing will audit daily staffing schedules 5 x per week x 12 weeks to ensure staffing is adequate for resident census. Staffing coordinator will review staffing per shift

Executive Director and Director of Nursing will conduct a daily labor meeting (Mon-Fri) as part of the morning meeting to ensure facility has adequate staffing for

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F 725	Continued From page 86 their best but when working short-staffed, they had to prioritize the care provided and residents were not getting the care needed. During an interview on 08/04/21 at 6:11 AM, NA #11 stated she normally worked second shift (3:00 PM to 11:00 PM) but frequently worked over on third shift (11:00 PM to 7:00 PM) due to staffing needs. NA #11 stated usually there were only 2 to 3 NA scheduled for the entire building which made it difficult to get resident care done such as incontinence rounds every 2 hours and answer call lights timely. During interviews on 08/04/21 at 6:21 AM AND 7:44 AM, NA #12 stated she normally worked second shift (3:00 PM to 11:00 PM) but frequently worked over on third shift (11:00 PM to 7:00 PM) due to staffing needs. NA #12 recalled on 07/29/21 she was the only NA assigned to west side on second shift and although other NAs helped when they could, there were 10 residents she wasn't able to provide incontinence care to during the shift and the third shift NA was informed so care could be provided. NA #12 stated on most nights there were only 3 NA scheduled for the entire building which made it difficult to get to everyone as often or frequently as needed and she felt rushed when providing resident care. During an interview on 08/04/21 at 6:31 AM, NA #13 stated she normally worked during the hours of 7:00 PM to 7:00 AM and the facility was frequently short-staffed. During the past 7 days she had worked, on at least 3 to 4 days, there were only 2 to 3 NA scheduled for the entire building. She explained when there were only 3 NA, she was able to "touch every resident" at	F 725	current census.Staffing coordinator and Director of nursing will review staffing prior to each change of shift to ensure adequate coverage for census. Executive Director will enlist the assistance from outside staffing agencies to supplement facility staff if needed. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Person Responsible: Executive Director and Director of Nursing Date of compliance is 9/20/2021	

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least once per shift; however, when there were only 2 NA, she was unable to get to everyone and unfortunately, some residents went without incontinence care.

During interviews on 08/04/21 at 6:55 AM and 3:52 PM, Nurse #8 stated she worked for a staffing agency and had only been working at the facility approximately one week with no formal orientation other than how to access the residents' medication administration records on the computer. Nurse #8 added the facility was short-staffed and sometimes there was only on NA assigned to the unit with weekends being the worst. She stated on 07/30/21 they only had 1 NA assigned to the unit and she tried to help the NA with incontinence care when she could because she knew the residents didn't want to be left wet or soiled. When working short-staffed, medications and treatments were her priority. Nurse #8 stated her body and mind were exhausted and "this was breaking her."

During a telephone interview on 08/06/21 at 9:01 AM, Unit Manager (UM) #2 stated staffing at the facility was a problem. UM #2 added when reporting to work residents were often found wet or soiled. She explained when there were only 2 or 3 NA scheduled for the entire building, they did the best they could but there was only so much they were able to do.

During a telephone interview on 08/06/21 at 9:24 AM, NA #14 stated she had been employed at the facility for almost 2 years and worked the hours of 11:00 PM to 7:00 AM. NA #14 indicated there were times there were only 2 NA scheduled for the entire building which made it difficult to provide residents with the care needed. She

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explained when short-staffed, she tried to pass ice and water so fluids were available to the residents, answer call lights as quick as she could to make sure there wasn't an urgent need and monitor for incontinence to keep the residents clean and dry. She added some of the residents were a 2-person assist and if both NA were tied up providing care to other residents, then there would be residents that went without incontinence care.

During a telephone interview on 08/06/21 at 2:36 PM, Nurse #9 reported when she had worked nights, there weren't enough NA scheduled and she would pitch in to help. She stated they tried to watch residents they knew were fall risks but couldn't be everywhere all the time and did the best they could.

During a telephone interview 08/11/21 at 10:56 AM, NA #15 reported she had been employed by the facility since 2014, worked weekends 7:00 AM to 11:00 PM and the facility was often short-staffed. NA #15 explained there was only one NA scheduled for her assigned section when she reported to work on 08/01/21 and only one NA the evening of 07/30/21. She added when she arrived to work on 08/01/21, the "smell of urine was overpowering" and when there was only one NA assigned, there was no way feed all the residents who needed assistance, keep the residents dry and give showers. NA #15 stated the Administrator would pitch in to help with incontinence care and showers when needed. NA #15 indicated she had discussed the staffing situation with the Administrator and although the facility did use agency staff, a lot of them would not show up for work. NA #15 stated "I'm burned out."

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SATURN NURSING AND REHABILITATION CENTER	1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262

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F 725	Continued From page 89	F 725		

During interviews on 08/01/21 at 12:08 PM and 8/05/21 at 03:58 PM, the facility Scheduler explained based on the current resident census and acuity needs, the preferred nursing staff minimums per day were: 5 nurses and 8 NAs 7:00 AM to 3:00 PM, 5 nurses and 8 NAs 3:00 PM to 11:00 PM and 3 nurses and 5 NAs 11:00 PM to 7:00 AM which was ideal, provided there were no-call outs. However, she indicated it was difficult to meet the preferred minimums, especially on the weekends, as they currently had 9 open nurse positions: 3 for first shift, 3 for second shift and 3 for third shift and 15 open NA positions: 6 for first shift, 7 for second shift and 2 for third shift which only added to the staffing challenges they currently faced. She added agency staff were utilized as much as possible; however, there were times they had no one to send. In addition, there had been a lot of call out outs on the evening shifts with no staff available for her to call on such short notice to come in and cover which would leave the shifts short. Frequently, she was pulled to the floor to cover as a NA or Med Aide when someone called out. The Scheduler stated on the days staffing was challenged, staff were not able to complete incontinence care rounds every 2 hours, residents might not get all their scheduled showers, dependent residents waited longer for assistance with meals, and call light response times took longer which had led to an increased number of falls. As a result, NA staff have voiced their frustration to her about not being able to give residents the care they deserved due to being so short staffed. The Scheduler confirmed administration was actively recruiting to fill the open positions and offered bonuses to staff when they signed up for extra shifts but she hated to

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F 725	Continued From page 90 ask them because they were all so burned out. During an interview on 08/01/21 at 3:42 PM, the Director of Nursing (DON) stated she had been employed at the facility for 4 months and they currently did not have a night shift weekend supervisor which left her on standby to cover when needed. The DON confirmed they faced staffing challenges due to open positions and call outs and utilized staffing agencies to supplement the schedule but the agencies did not always have someone to send. She explained the facility offered staff bonuses when they picked up extra shifts as well as offered sign-on bonuses for Nurses. She added the hiring process was ongoing and while they had received promising applicants some either didn't show up for the interview or orientation when hired. During an interview on 08/05/21 at 6:15 PM, the Administrator stated the hiring process was ongoing confirmed the facility faced a staffing challenge and stated their recruitment process remained ongoing. She added although they had received promising applicants, they either wouldn't call back or show up for a scheduled interview. The Administrator explained in addition to utilizing agency staff, they took flyers to local colleges to try and recruit NA graduates, advertised on social media sites, and offered sign-on bonuses for new staff. The Administrator stated she came in and worked the evening of 07/30/21 with another NA and while they do the best they can for the residents, she realized things were not getting done such as residents not getting the incontinence care like they need due to the current staffing challenges.	F 725		
F 802 SS=F	Sufficient Dietary Support Personnel	F 802		9/20/21

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F 802	Continued From page 91 CFR(s): 483.60(a)(3)(b) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to have sufficient dietary staff to serve meals on time and failed to train the assistant dietary manager how to follow menus when serving portion sizes to residents. Findings included: This tag is cross-referred to: 1. F 809 Based on observations, interviews with residents, family and staff and record review, the facility failed to provide meals on time according to the meal schedule. This had the potential to affect 106 of 108 residents.	F 802	1. Facility failed to have sufficient dietary staff to serve meals on time and failed to train the assistant dietary manager how to follow menus when serving portion size. Assistant Dietary manager will be in-serviced by 9/20/2021 regarding following menus and portion size. 2. All residents have the potential to be affected. An audit will be completed by the Executive Director and the Certified Dietary Manger of the last 14 days of dietary staffing to ensure dietary staffing was sufficient and that meal delivery was on time. Audit to be completed by 9/20/2021.	

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F 802	Continued From page 92 2. An observation of the lunch meal tray line began on 8/3/21 at 11:45 AM. The Assistant Dietary Manager (ADM) was serving the food behind the steam table. She was using (2) separate 4-ounce spoodles to serve the roasted potatoes and spinach vegetable dishes. The first meal tray was served a ¾ of a serving of the 4-ounce spoodle of spinach. At 11:48 AM, Dietary Aide #2 called out for 2 large portion diet orders. The ADM served 1 scoop of potatoes plus 2 more potato pieces and ¾ of a serving of the 4-ounce spoodle plus ¼ serving more. At this time, the Dietary Manager (DM) took over behind the hot line and began serving the rest of the lunch meals. The tray line was halted numerous times during lunch meal service. At 11:53 AM the tray line was abbreviated when the DM was observed removing spinach from the steamer and placed on the stove in a sauté pan. The DM stated at the time of the observation he ran out of spinach on the hot line and would ask the cook (ADM) why she did not prepare enough spinach. He further stated she was filling in because the regular cook was off that morning. The tray line resumed at 12:23 PM. At 12:30 PM, the tray line was stopped again to add spinach from the steamer. The tray line resumed at 12:40 PM. Interview with the ADM on 8/3/21 at 2:02 PM revealed she has not received any training in food preparation since she was hired. She stated she has only observed the DM and Cook #1 a few times because the dietary department has been so short staffed. The ADM further stated there has not been anyone to train her since she was hired 3 weeks ago. She indicated she has referenced the recipe book and sometimes asked Dietary Aide #1, who has worked in the dietary department for 16 years, about portion sizes.	F 802	3. Executive Director to educate the Certified Dietary Manager on sufficient staffing and all dietary staff to be educated on expectation of meal delivery. This education will be added to new hire packet. Education will be completed by 9/20/2021. Executive Director and Certified Dietary Manager will conduct a daily labor meeting (Mon-Fri) as part of the morning meeting to ensure kitchen has adequate staffing. Weekend Manager will review staffing on Saturday/Sunday. Executive Director or designee will review staffing prior to each dietary shift to ensure adequate staffing. If staffing is inadequate the facility will enlist its crossed trained staff that are available as well as the use of agency staffing. Executive Director and/or Certified Dietary Manager will audit daily staffing schedules 5 x per week x 12 weeks to ensure staffing is adequate for kitchen needs. Certified Dietary manager or designee will log meal delivery times for all meals daily to each unit x 12 weeks. Executive Director will review these audits weekly to ensure adequate staffing and timely meal deliveries. 4. Data obtained during the audit	

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F 802	Continued From page 93 The ADM revealed meals were late on her first day of work, which was July 19th, because a cook quit that day. Breakfast was served around 9:30-9:45 AM and lunch did not go out until 1:30 PM. The Administrator and a few nurses came to help in the kitchen. Interview with the DM on 8/3/21 between 1:01 PM and 1:23 PM revealed when the ADM was hired, she said she did not cook and had a couple days of training with cooking/preparation. She has not worked with the DM since she had been hired. The lunch tray line on 8/3/21 was not started on time because there was not an adequate amount of spinach already prepared. The Registered Dietitian (RD) was interviewed on 8/4/21 at 3:18 PM. She revealed she provided clinical support, performed kitchen inspections monthly, and answered questions but did not train staff. 3. Meal and Cart Times sheet stated the West Hall should have been served breakfast at 7:40 AM. South Hall should have been served lunch at 12:10 PM, and the last hall was to be served at 12:30 PM. An observation on 8/3/21 at 11:05 AM showed 2 staff working in the kitchen: 1 Dietary Aide and the ADM. At 12:50 PM, the first tray on South Hall was passed. On 8/4/21 at 10:05 AM, the breakfast meal and beverage carts arrived on West Hall. On 8/4/21 at 2:41 PM, an observation of Cook #1, the DM, the Administrator and Unit RN Manager #1 were working the lunch meal tray line in the kitchen (Meal & Cart Times sheet stated the last hall was supposed to be served at 12:30 PM). On 8/5/21 at 11:20 AM, an interview was	F 802	process will be analyzed for patterns and trends and reported to QAPI by the Certified Dietary Manager monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Person Responsible: Executive Director and Certified Dietary Manager Date of compliance is 9/20/2021	

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F 802	Continued From page 94	F 802		

conducted with Dietary Aide #1 (Faith) and she revealed she was told by the DM 2 dietary staff (1 aide and 1 cook) would have to cover an evening shift "the other night. She stated it has been like this for a long time despite interviews for potential employees being conducted. DA #1 indicated meals were served hours late, and the DM has become more relaxed about the tray line start times.

The ADM was interviewed on 8/3/21 at 2:02 PM, and she revealed meals were late on her first day of work, which was July 19th of this year, because a cook quit that day. She stated breakfast was served around 9:30-9:45 AM and lunch did not go out until 1:30 PM. The Administrator and a few nurses came to help with meal service on July 19th.

During an interview with the DM on 8/3/21 between 1:01 PM and 1:23 PM, he revealed the dietary department has been struggling with short staffing and 3 staff are needed for each shift. Sometimes the DM and 1 Dietary Aide covered a shift. He stated if breakfast was late then that threw off the next few meals. A few weeks ago, on a Saturday, breakfast was served at 10:00 AM and the lunch line was started around 12:00 PM. He recalled the latest dinner was served at 8:00 PM. On 8/5/21 at 3:37 PM when asked about the late meals on 8/4/21, the DM stated the cook was running late and the ADM went into the kitchen and got things started. He arrived around 7:20 AM and he was the only DA on the line for breakfast. The DM stated tray line service for breakfast was started at 8:00 AM and it took 2 hours to get the breakfast line completed. He called in another DA, who came in around 12:00 PM. Lunch was delayed and the tray line was

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F 802	Continued From page 95 started around 2:00 PM, which took about an hour to complete. The Registered Dietitian (RD) was interviewed on 8/4/21 at 3:18 PM. She stated she was aware the dietary department was short staffed, and she provided support by entering data into the Minimum Data Set (MDS) as well as weights into the electronic medical record (EMR). She stated she has witnessed the Administrator helping in the kitchen during meal service and the corporate office provided a traveling cook at one time. On 8/4/21 at 12:29 PM, an interview was conducted with the Administrator. She revealed breakfast was late today because the DM a staff member call out and she was notified at 6:45 AM. Cook #1 was alone in the kitchen and the Administrator went to assist. She stated there have been dietary staffing challenges in the past and she has worked in the kitchen for several weeks. The Administrator further stated when a summer intern was in the facility, they spent a lot of time in dietary, along with other staff who have helped. She stated they have hired a cook and he did not show up, so the Administrator had to cook. All staff that have assisted in the kitchen have not received formal training. The Administrator indicated the latest meal delivery times occurred in July 2021, which were 9:30 AM for breakfast, 2:00 PM for lunch, and 8:00 PM for dinner. She stated these late mealtimes were unreasonable.	F 802		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides-	F 804		9/20/21

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F 804	Continued From page 96 §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interviews, the facility failed to serve food that was palatable and at an appetizing temperature to 4 of 7 sampled residents review for food palatability (Resident #s: 46, 55, 83 and 87). The findings included: 1. Interviews with residents on 8/1/21, revealed four of six residents interviewed voiced concerns about the temperature and taste of foods. a. Resident #46 was admitted to the facility 5/25/21. Diagnoses included dysphagia, gout and anemia. An admission Minimum Data Set (MDS) dated 5/26/21 assessed Resident #46 with clear speech, adequate hearing/vision, usually able to understand and be understood, cognitively intact, and required no staff assistance with eating. During an interview on 8/1/21 from 12:25 PM to 12:38 PM, Resident #46 stated the food was always cold and did not receive enough. When he tasted the meat portion of the lunch meal during the interview, he spit it out and stated it was lukewarm and tough.	F 804	1. Facility failed to serve food that was palatable and at an appetizing temperature to Residents #46, #55, #83, and #87. Certified Dietary Manager will meet with Residents by 9/20/2021 to update preferences and ensure that temperatures are appetizing. 2. All residents have the potential to be affected. 3. Executive Director to educate the dietary staff on expectations of serving foods that are palatable and at the resident□s preferred temperature. Education also included expectations of reheating a meal that was at undesired temperature as well as offering an alternate to residents. This education will be added to new hire packet. Education will be completed by 9/20/2021. Certified Dietary Manager will interview residents to ensure food is palatable and at their preferred temperature. Audit will be conducted with 5 residents per week x 4 weeks, 3 residents per week x 4 week, then 1 resident per week x 4 weeks.	

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F 804	Continued From page 97 b. Resident #55 was readmitted to the facility 1/25/21. Diagnoses included diabetes, stroke, hypertension, and chronic kidney disease. A quarterly MDS dated 5/9/21 assessed Resident #55 with clear speech, adequate hearing/vision, able to be understood, understands others, intact cognition and fed herself but required supervision with 1 staff person assistance with meals. Resident #55 was interviewed on 8/1/21 at 01:51 PM and stated the food was always cold. She further stated she refused to eat cold food and would not ask staff to warm it up. c. Resident #83 was admitted to the facility 3/13/21. Diagnoses included diabetes, paraplegia, coronary artery disease and hyperlipidemia. A quarterly MDS dated 6/19/21 assessed Resident #83 with adequate hearing/vision, clear speech, understood by others, understands others, intact cognition, and was independent with eating. An interview with Resident #83 on 8/1/21 at 1:01 PM revealed the food was "terrible," arrived late and cold. On 6/13/21, Resident #83 stated dinner arrived at 9:00 PM and the hamburger meat was raw. d. Resident #87 was readmitted to the facility 5/29/21. Diagnoses included dementia, heart failure, hypertension, and diabetes. A quarterly MDS dated 6/25/21 assessed Resident #87 with intact cognition, clear speech, able to understand, able to be understood,	F 804	Executive Director will review these audits weekly to ensure resident are receiving palatable foods at preferred temperatures. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Certified Dietary Manager monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Person Responsible: Executive Director and Certified Dietary Manager Date of compliance is 9/20/2021	

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F 804	Continued From page 98	F 804		

adequate hearing/vision, and required limited assistance from staff with eating.

An interview with Resident #87 on 8/1/21 at 1:51 PM revealed preferences were not fulfilled on meal tray after kitchen staff were notified and when asked for what they want instead, it takes a long time to receive.

A test tray was requested on 8/3/21 at 12:41 PM for a regular lunch meal tray. The meal was plated at 12:43 PM with roasted potatoes, steamed spinach, and baked chicken. Iced tea and ice cream were included on the test tray. The CDM left the kitchen at 12:47 PM with the test tray and arrived on the South Hall at 12:47 PM. All residents on the South Hall were served by 12:58 PM and the test tray was sampled. Margarine and salt were added to the hot foods and the margarine remained congealed. The CDM and surveyors sampled the foods and observed the following: the chicken was without visible steam, while the roasted potatoes and spinach had visible steam. The CDM stated the chicken had "good flavor but it could be hotter." The spinach tasted like spinach with no seasonings added and was warm. The potatoes had good flavor slightly warm but not hot. The iced tea had no ice and the CDM stated "it usually has ice."

During an interview with the Certified Dietary Manager (CDM) on 8/13/21 at 9:18 AM he stated he was not aware of the dietary complaints from the September or November 2020 Resident Council Meetings (RCM). The CDM indicated the Activities Director (AD) usually provided him with a grievance from any RCM with dietary issues. He was then required to correct the grievance in

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F 804	Continued From page 99 writing and give back to the AD. If a complaint came from a particular resident, then he would return the corrected grievance to the Social Worker. He stated he did not receive a grievance for either September or November 2020. When planning for the next meal of the month, the Resident Council president usually provided any feedback of the previous month's meal. The CDM stated she did not tell him about the dry ribs, and it has been several months since he received a grievance from the RCM. The Administrator stated in an interview on 8/5/21 at 3:07 PM that residents should receive foods served at acceptable taste/temperatures.	F 804		
F 808 SS=E	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews and record review, the facility failed provide a therapeutic diet to 5 of 5 residents with a diet order for no potassium rich foods (Resident #51) and liberalized renal diet (a diet that recommends foods low in potassium and phosphorus) (Residents #31, #33, #34, #105). Spinach, a vegetable high in potassium and phosphorous was served to 4 residents with a	F 808	1. Facility failed to provide a therapeutic diet to resident #51 with a diet order for no potassium rich foods and for residents #31, #33, #34, and # 105 with diet orders for liberalized renal (low potassium and phosphorus). Education provided to Assistant Dietary Manager for following therapeutic spreadsheet for vegetables.	9/20/21

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F 808	Continued From page 100 diet order for a liberalized renal diet (Residents #31, #33, #34, #105) and a vegetable was not served to a resident (Resident #51) with a diet order for no potassium rich foods. The findings included: Review of the medical record revealed the following: 1a. Resident #31 was admitted to the facility on 3/1/21 with diagnoses to include end stage renal disease, among others. A diet order dated 3/1/21 recorded liberalized renal, no added salt diet, no water pitcher at the bedside. 1b. Resident #33 was re-admitted to the facility on 7/30/21 with diagnoses to include end stage renal disease, among others. A diet order dated 7/30/21 recorded liberalized renal, large meat portions. 1c. Resident #34 was admitted to the facility on 10/20/20 with diagnoses to include end stage renal disease, among others. A diet order dated 10/20/20 recorded liberalized renal, large meat portion. 1d. Resident #51 was admitted to the facility on 10/31/20 with diagnoses to include end stage renal disease, among others. A diet order dated 11/2/20 recorded reduced concentrated sweets, no high potassium rich foods. 1e. Resident #105 was admitted to the facility on 2/23/21 with diagnoses to include end stage renal disease, among others. A diet order dated 2/23/21 recorded liberalized renal.	F 808	2. All residents with alternate therapeutic diets have the potential to be affected. 3. Executive Director to educate dietary staff on therapeutic diets and expectations for alternate items. Education will be added to Dietary Orientation. Education will be completed by 9/20/2021. Certified Dietary Manager or designee with audit meal trays for appropriate therapeutic diet. Audit will be conducted with 5 residents per week x 4 weeks, 3 residents per week x 4 week, then 1 resident per week x 4 weeks to ensure that therapeutic diet was served based on physician orders. Executive Director will review these audits weekly to ensure residents with therapeutic diets were received based off physician orders. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Certified Dietary Manager monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Person Responsible: Executive Director and Certified Dietary Manager Date of compliance is 9/20/2021	

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	345489	A. BUILDING _____ B. WING _____	C 08/13/2021

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F 808	Continued From page 101	F 808		

During a continuous observation of the lunch meal tray line on 8/3/21 from 11:45 AM - 12:41 AM, the Assistant Dietary Manager (ADM) was observed to plate a 3-ounce portion of spinach for Residents #31, #33, #34, and #105 and Resident #51 did not receive a vegetable. There was no other vegetable available on the lunch meal tray line.

Review of the lunch meal tray cards and Diet Report provided by the facility revealed Residents #31, #33, #34, and #105 received a liberalized renal diet and Resident #51 had a diet order for no potassium rich foods.

Review of the therapeutic spreadsheet revealed green beans should be served as the vegetable to residents with a liberalized renal diet order or a diet order for no potassium rich foods. Green beans were not available on the lunch meal tray line.

An interview with the ADM occurred on 8/05/21 at 3:35 PM. The ADM stated that she was hired in her role two weeks ago and had not received formal training in this role. The ADM stated in her previous responsibilities as a dietary supervisor, she did not cook, so since she assumed her role as ADM, she had to ask questions because she had not been trained. The ADM stated that she did not review the therapeutic spreadsheet when she prepared the lunch meal that day (8/3/21) and did not notice that green beans was the alternate vegetable for residents with diet orders for no potassium rich foods or residents who received a liberalized renal diet. The ADM further stated that the green beans were not prepared and that this was an oversight.

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F 808	Continued From page 102 During an interview on 8/3/21 at 12:03 PM, the CDM stated that when the ADM was hired two weeks ago, she stated, "I don't cook", and so far, she had only received a couple days of training with two of the cooks. He stated that the ADM had not yet trained with him and that she would need to have more days for training. The CDM further stated that he worked as the evening cook the day before, and therefore he was not in the kitchen to provide oversight for the lunch meal that day (8/3/21). He stated the ADM was filling in because the regular cook was off. The CDM stated that it was an oversight regarding the availability of green beans for residents with diet orders for liberal renal or no potassium rich foods. He stated that these residents should not receive spinach because it is rich in phosphorus and potassium. A telephone interview occurred with the consultant Registered Dietitian (RD) on 8/04/21 at 3:18 PM. The RD stated that she rounded at the facility every other week, reviewed/approved menus, and conducted monthly kitchen inspections. The RD further stated that she was not aware of dietary concerns related to items on the menu not being available, but that residents should receive foods according to their diet order.	F 808		
F 809 SS=E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care.	F 809		9/20/21

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F 809	Continued From page 103 §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with residents, family and staff and record review, the facility failed to provide meals on time according to the meal schedule. This had the potential to affect 106 of 108 residents. The findings included: 1a. A meal schedule was observed posted in the dining room on 8/1/21 at 12:40 PM. Meal delivery times were recorded as follows: · Breakfast - 7:20 AM - 8:05 AM · Lunch - 11:35 AM - 12:30 PM · Dinner - 5:30 PM - 6:20 PM A telephone interview with a family member occurred on 8/1/21 at 11:44 AM. The family member stated that during a visit to the facility on 7/9/21 lunch was served to Resident #78 (cognition severely impaired per quarterly Minimum Data Set assessment dated 6/4/21) between 2:00 PM - 2:30 PM and dinner on 7/12/21 was served to Resident #78 at 8:00 PM.	F 809	1. Facility failed to provide meals on time according to the meal schedule. Education was provided on ensuring staff follows the menu/recipes to ensure appropriate serving sizes are prepared prior to starting the tray line. Available trained department heads are available to assist as needed to ensure timely delivery of meal trays. Snacks were offered to residents till meal trays were provided. 2. All residents have the potential to be affected. 3. Executive Director to educate dietary staff on expectation of meal delivery. Education will be added to New Hire Orientation. Education will be completed by 9/20/2021. Certified Dietary manager or designee will log meal delivery times for all meals daily to each unit x 12 weeks. Executive Director will review these audits	

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F 809	Continued From page 104 Continuous observation of the lunch meal tray line occurred on 8/1/21 from 12:45 PM - 1:15 PM. The lunch meal tray line was observed in progress at 12:45 PM and ended at 1:15 PM. Continuous observations of meal delivery to residents on 8/1/21 revealed lunch meal carts were delivered to nursing units and then delivered to residents between 12:33 PM and 1:43 PM. A continuous observation of the lunch meal tray line occurred on 8/3/21 from 11:45 AM - 12:43 PM. During the observation, the lunch meal tray line stopped for the following: · 11:53 AM for 11 minutes, to prepare/add steamed spinach to the tray line · 12:14 PM for 9 minutes, to prepare/add pureed spinach to the tray line · 12:30 PM for 10 minutes, to prepare/add steamed spinach to the tray line Resident meals were delivered on 8/3/21 to the nursing units and then to residents between 12:43 PM to 2:02 PM. 1b. A Resident Council meeting occurred on 8/2/21 at 3:00 PM. During the meeting 5 of 5 residents who attended (Residents #7, #43, #57, #63 and #75) stated that meals were usually delivered per the posted schedule, but depending on the staff available in the kitchen, at times meals were delivered late. Residents expressed that on Sunday, 8/1/21, they received all meals later than the meal schedule that was posted. The Certified Dietary Manager (CDM) stated in an interview on 8/3/21 at 1:23 PM that the tray line did not start on time which caused meals to be served late on Sunday, 8/1/21. He further stated that on Tuesday 8/3/21 meals were served late	F 809	weekly to ensure adequate staffing and timely meal deliveries. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Certified Dietary Manager monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Person Responsible: Executive Director and Certified Dietary Manager Date of compliance is 9/20/2021	

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F 809	Continued From page 105	F 809		

due to insufficient staffing and that staff did not prepare enough food, per the menu, which caused staff to stop the tray line to prepare more food. The CDM stated that the dietary department struggled with sufficient staff to carry out dietary services for several months and at times the dietary department operated with one cook and one dietary aide (DA) to prepare meals for 108 residents. He stated that if the breakfast meal was delivered late, that caused lunch and supper to also be served late. The CDM stated that a couple weeks ago on a Saturday (date unknown), breakfast was delivered to residents at 10:00 AM, lunch at 1:00 PM and dinner was delivered at 8:00 PM. He stated this also occurred on a holiday weekend in July 2021. The CDM further stated that meals were delivered to residents late a lot in the last few months. The CDM stated that as a result, his responsibilities included working as a cook, DA, putting away stock, ordering foods and interviewing staff to fill dietary vacancies. The CDM stated that for residents to receive meals delivered per the meal schedule, he needed 3 staff in his department on each shift. The CDM also stated that residents had expressed to him they were upset regarding receiving meals late and that he was aware of this concern voiced during Resident Council meetings.

The Assistant Dietary Manager (ADM) was interviewed on 8/03/21 at 2:02 PM. The ADM stated that she was hired in her role three weeks ago and had not received formal training in this role. The ADM stated in her previous responsibilities as a dietary supervisor, she did not cook, so since she assumed her role as ADM, she had to ask questions because she had not been trained. The ADM stated that the dietary department was so short staffed since she

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F 809	Continued From page 106	F 809		

started, there had not been anyone to train her. As a result, she relied on using the recipes, watching other staff, and asking questions. The ADM stated she prepared lunch that day (8/3/21) but because she had very little experience as a cook, she did not know how to calculate the amount of each food item necessary to feed 108 residents, so she did not prepare enough food which delayed the lunch meal because more food had to be prepared. The ADM recalled that on her first day of employment, 7/19/21, the cook quit that day which resulted in meals being served to residents late. The ADM stated that on that day (7/19/21) the first breakfast cart left the kitchen at 9:45 AM and the first lunch cart left the kitchen at 1:30 PM.

During a telephone interview on 8/03/21 at 5:00 PM, Cook #1 stated that in the 2 weeks he was employed by the facility, meals were about 25 minutes late leaving the kitchen. He further stated that this occurred twice because the pureed bread or the alternate soup had not been prepared. He stated that the staff had to stop the tray line to prepare items that were forgotten. Cook #1 stated that these errors occurred when the dietary department was short staffed having only a cook and a DA to prepare the meal.

An interview was conducted on 8/04/21 at 12:29 PM with the Administrator and Director of Nursing (DON). The interview revealed that on 8/4/21, the breakfast meal was served late due to dietary staff call out. The Administrator stated that she was notified on 8/4/21 at 6:45 AM, that Cook #1 was in the kitchen alone. The Administrator stated that she went to the kitchen to assist. She stated that due to repeated staffing challenges in the dietary department, she provided regular dietary

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F 809	Continued From page 107 assistance for the past several weeks and daily for a while during the summer months. The Administrator further stated that assisting in the dietary department was a team effort because applicants to that department either did not pass the background check, the drug test, or had no formal training. She stated that due to staffing challenges mealtimes were impacted and that for 2 weeks in July 2021 there were times that breakfast was served as late as 9:30 AM, lunch as late as 2 pm, and dinner as late as 8:00 PM. The Administrator stated she was aware that residents felt that the quality of foods was affected due to the timeliness of meals. Additionally, the Administrator stated that serving lunch at 2:00 pm was not reasonable neither was serving dinner at 8:00 PM. She stated that dinner should be served earlier. The consultant registered dietitian (RD) was interviewed by phone on 8/04/21 at 3:18 PM. The RD stated that she provided clinical support to the facility and she was aware of the facility's staffing challenges. As a result, she began providing support with dietary assessments and entering weight data into resident's electronic records. The RD stated that the CDM worked long hours to cover shifts and that she also observed the Administrator assisting in the kitchen. The RD further stated that the corporate office provided a traveling cook only once for support, and that the primary corporate role was clinical support.	F 809		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		9/20/21

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F 812	Continued From page 108 §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 observation, staff interview and review of records, the facility failed to 1) maintain milk, a potentially hazardous food, 41 degrees Fahrenheit (F) or below on the lunch meal tray line, 2) discard potentially hazardous foods with signs of spoilage (iceberg lettuce, bell peppers, bananas), 2) label and date opened food items (turkey breast, deli ham), 3) store foods in a closed container (vegetable beef soup) and 4) store bananas 56 - 60 degrees Fahrenheit (F) per manufacturer recommendations. This occurred in 1 of 1 refrigerator, freezer, and dry storage. The findings included: 1a. A continuous observation of cold storage (walk in refrigerator and freezer) and dry storage occurred on 08/01/21 from 1:01 PM to 1:39 PM and revealed the following: The walk-in refrigerator was observed with: -An unopened clear plastic bag of crisp head	F 812	1. Facility failed to 1) maintain milk, a potentially hazardous food, 41 degrees Fahrenheit (F) or below on the lunch meal tray line, 2) discard potentially hazardous foods with signs of spoilage (iceberg lettuce, bell peppers, bananas), 2) label and date opened food items (turkey breast, deli ham), 3) store foods in a closed container (vegetable beef soup) and 4) store bananas 56 - 60 degrees Fahrenheit (F)per manufacturer recommendations. All items discarded on 8/1/2021 and milk discarded on 8/3/2021. 2. Certified Dietary Manager will audit the kitchen to ensure all opened items are properly dated and stored and items are stored at the appropriate temperatures based on manufacturer recommendations. This audit will be completed by 9/20/2021.	

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F 812	Continued From page 109 lettuce (Iceberg) with brown leaves surrounded by a dark brown liquid substance. -An opened package of deli turkey breast, unwrapped, stored in a box with an illegible date recorded on the package and surrounded by an opaque liquid substance. -An opened package of deli ham was wrapped in plastic and stored in a box with the date "6/24/21" recorded on the box. The deli ham did not have a date of opening recorded on the package. -The freezer was observed with a 4-pound plastic container of vegetable beef soup that was stored with a plastic cover that was unsealed; the soup was open to air. -A case of bananas was observed stored on the lower shelf of the cook's prep table. All the bananas were covered with large brown/black spots. Manufacturer instructions recorded on the box to store the bananas 56 - 60 degrees F. 1b. During a continuous kitchen observation on 8/3/21 from 11:33 AM to 12:07 PM, the following was noted: -At 11:33 AM, dietary staff removed a plastic container from refrigeration filled with 8-ounce cartons of milk in a pool of water which was placed on the lunch tray line. -At 11:37 AM, the Assistant Dietary Manager (ADM) monitored the temperature of the milk and obtained a temperature of 46 degrees F. The milk temperature was communicated to the Certified Dietary Manager (CDM) and he stated that the milk was just delivered. -At 11:45 AM, the lunch meal tray line began, and 2 cartons of milk were placed on meal trays for delivery to residents. -At 12:07 PM, staff pushed the cart towards the door for delivery to residents. Staff confirmed that the cart was ready for delivery.	F 812	3. Executive Director to educate the dietary staff on label and dating opened items and storing items in proper areas, at appropriate temperatures based on manufacturer recommendations. Education will be added to New Hire Orientation. This education will be completed by 9/20/2021. Certified Dietary Manager will audit the kitchen to ensure open items are dated and items are stored properly. This audit will be conducted 5 x per week x 12 weeks. Executive Director will review results of the audits to ensure that open items are dated, and items are stored properly. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Certified Dietary Manager monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Person Responsible: Executive Director and Certified Dietary Manager Date of compliance is 9/20/2021	

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F 812	Continued From page 110	F 812		

-At 12:07 PM, temperature monitoring of the milk was requested by the surveyor and a temperature of 49 degrees F was obtained by the ADM. The CDM stated, "it's gone up" and instructed staff not to serve any of the milk.

During an interview with the CDM on 8/1/21 at 1:39 PM, he stated that food storage was monitored twice weekly when stock was delivered. He stated that he received a delivery on Friday, 7/30/21 but he was also the cook and dishwasher that day, so he did not get a chance to check food storage for items that needed to be discarded or labeled. He confirmed that the lettuce and bell peppers showed signs of spoilage and should have been discarded, all opened foods should be stored labeled/dated, and all foods should be stored in a closed container.

An interview on 8/01/21 at 2:56 PM with the Maintenance Director revealed the current ambient temperature in the dietary department was 74 - 75 degrees F.

A follow up interview and observation of the kitchen on 8/3/21 at 1:23 PM revealed a case of bananas with large brown/black spots was stored on the lower shelf of the cook's prep table. The CDM stated that bananas were typically stored on the lower shelf of the cook's prep table. He further stated that he was not aware of the manufacturer recommendations recorded on the box to store bananas 56 - 60 degrees F and he was not aware that the current ambient temperature in the kitchen was 74 - 75 degrees. He also stated that he did not order enough milk with the last order to last until the lunch meal on 8/3/21. He stated that milk was delivered on 8/3/21 shortly after 11:00 AM and by the time he was able to put the stock

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F 812	Continued From page 111 away the milk was not refrigerated long enough to be served 41 degrees or below for the lunch meal that day (8/3/21). The CDM further stated that at the time staff identified the milk temperature of 46 degrees F, he should have directed staff not to serve the milk. The Administrator was interviewed on 8/4/21 at 12:29 PM and stated that all food items should be monitored for signs of expiration, stored covered and labeled with a date of storage. She further stated that produce should be stored according to manufacturer's recommendations and milk should be kept in refrigeration at 41 degrees or below.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F 842		9/20/21

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SATURN NURSING AND REHABILITATION CENTER	1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262

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F 842	Continued From page 112	F 842		

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and

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F 842	Continued From page 113 determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to maintain an accurate Medication Administration Record (MAR) for the administration of oxygen no longer in use for 1 of 1 resident reviewed for respiratory care (Resident #72). Findings included: Resident #72 was admitted to the facility on 11/02/17 with diagnoses that included congestive heart failure and asthma. The quarterly Minimum Data Set (MDS) dated 06/06/21 assessed Resident #72 with intact cognition for daily decision making. The MDS noted Resident #72 received oxygen therapy while a resident. Review of Resident #72's July 2021 Medication Administration Record revealed a physician's order dated 12/17/20 for oxygen at 2 Liters Per Minute (LPM), continuous. Further review noted the order was initialed on the MAR as administered daily at 6:30 AM, 2:30 PM and 10:30 PM. Observations conducted of Resident #72 on 08/01/21 at 12:50 PM, 08/03/21 at 9:00 AM, 08/03/21 at 4:33 PM and 08/05/21 at 9:30 AM revealed no supplemental oxygen in use.	F 842	1. Facility failed to maintain an accurate Medication Administration Record (MAR) for the administration of oxygen no longer in use for Resident #72. Order for oxygen was discontinued on 8/5/2021. 2. An audit of all residents with oxygen orders to ensure that oxygen is provided as ordered by the physician. Audit will be completed by 9/20/2021 by Director of Nursing. 3. Licensed staff to be educated by Assistant Director of Nursing regarding the importance of following physician orders for oxygen and documenting administration correctly on the Medication Administration Record. Education will be added to New Hire Orientation. This education to be completed by 9/20/2021. Audits will be conducted by Director of Nursing or designee to monitor residents with oxygen to ensure oxygen is provided as ordered by the physician and properly documented on the Medication Administration Record. This audit will be conducted on all residents with continuous oxygen 5 x per week x 4 weeks, 3 x per week x 4 weeks, 1 x per week for 4.	

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F 842	Continued From page 114 During an interview on 08/01/21 at 12:50 PM, Resident #72 stated she did not use supplemental oxygen. An interview was conducted with Nurse #4 on 08/05/21 at 9:33 AM who was frequently assigned to provide Resident #72's care. Nurse #4 reviewed Resident #72's current MAR and confirmed there was an active physician's order for continuous oxygen at 2 LPM and stated Resident #72 did not use supplemental oxygen. Nurse #4 could not explain why she had initialed the order on the MAR as completed and stated she had done so in error. An interview and subsequent observation of Resident #72 were conducted with the Nursing House Supervisor (NHS) on 08/05/21 at 9:40 AM. The NHS reviewed Resident #72's current MAR and confirmed she had an active physician's order for continuous oxygen at 2 LPM. Upon observation, Resident #72 was lying in bed and appeared to be resting comfortably. The NHS verified Resident #72 had no oxygen in use and stated she showed no signs of respiratory distress or trouble breathing while on room air. The NHS could not explain why there was a physician's order for Resident #72 to receive continuous oxygen or why nursing staff had initialed oxygen was administered daily on Resident #72's MAR. He added the physician should have been notified that Resident #72 did not receive continuous oxygen so that the order could be discontinued. An interview with the Administrator was conducted on 08/05/21 at 9:42 AM. The Administrator explained Resident #72 may have used supplemental oxygen earlier in the year but	F 842	4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Person Responsible: Director of Nursing Date of compliance is 9/20/2021	

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F 842	Continued From page 115 had not used any for a while. The Administrator stated she had noticed Resident #72's order for continuous oxygen when she completed the 6:30 AM medication pass on 07/29/21 and initialed the MAR as "not administered" with the intention of notifying the Medical Director (MD) for the order to be discontinued since it was not in use. She could not explain why nursing staff continued to initial the order for oxygen as administered daily on Resident #72's MAR and stated they should have notified the MD for the order to be discontinued since it was no longer in use by Resident #72. A telephone interview was conducted with the MD on 08/06/21 at 9:26 AM. The MD stated the pharmacy was usually good to inform him of orders that needed to be discontinued, especially when there was an order for continuous oxygen that the resident was not using. The MD did not recall being notified by anyone that Resident #72 was not using supplemental oxygen and stated he would have liked to have known so that the order could be discontinued.	F 842		
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	F 880		9/20/21

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F 880	Continued From page 116	F 880		

and control program (IPCP) that must include, at a minimum, the following elements:

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

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

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F 880	Continued From page 117 by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to implement their infection control policies and the Center for Disease Control and Prevention (CDC) guidelines for the use of Personal Protective Equipment (PPE) when 1 of 1 housekeepers (Housekeeper #1) failed to wear an N-95 mask, eye protection, and a gown when mopping the floor of 1 of 1 resident (Resident #309) reviewed for Enhanced Droplet Precautions, failed to place a Contact Isolation sign on the door of 1 of 3 residents reviewed for infection control (Resident #22), failed to perform hand hygiene during dressing changes for 1 of 4 residents (Resident #44) reviewed for pressure ulcers, 1 NA (NA #8) failed to perform hand hygiene before delivering a meal tray and handled food with her bare hands for meals being served on 1 of 3 halls, and 2 dietary staff members (Cook #1 and Dietary Aide #1) failed to wear a face mask covering their nose and mouth for 2 of 4 dietary staff reviewed for appropriate PPE use. These failures occurred during a COVID-19 pandemic.	F 880	1. The facility failed to implement their infection control policies and the Centers for Disease Control and Prevention (CDC) guidelines for the use of Personal Protective Equipment (PPE) when Housekeeper #1 failed to wear an N-95 mask, eye protection, and a gown when mopping the floor of Resident #309 who was on Isolation Precautions: Enhanced Droplet, facility failed to place a Contact Isolation sign on the door of Resident #22, Nurse #9 failed to perform hand hygiene during dressing changes for Resident #44, NA #8 failed to perform hand hygiene before delivering a meal tray and handled food with her bare hands for meals being served, and Cook #1 and Dietary Aide #1 failed to wear a face mask covering their nose and mouth. These failures occurred during a COVID-19 pandemic. Housekeeper #1 did not return to work after 8/1/2021. Contact Isolation signage was placed on Resident #22 door	

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F 880	Continued From page 118 The findings included: 1. Review of the facility's policy titled "COVID-19 Response Guidelines" last updated 06/16/21 read in part: PPE for New Admission Area A. Health Care Personnel (HCP) should wear an N-95 or higher-level respirator, eye protection (i.e., goggles or a face shield that covers the front and sides of the face), gloves, and gown when caring for those residents. The CDC guidance entitled, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic," updated 02/23/21 indicated in part the following statements under the section "Recommended infection prevention and control (IPC) practices when caring for a patient with suspected or confirmed SARS-CoV-2 infection": The PPE recommended when caring for a patient with suspected or confirmed COVID-19 includes the following: Respirator -Put on an N-95 respirator (or equivalent or higher-level respirator) before entry into the patient room or care area Eye Protection -Put on eye protection (i.e. goggles or a face shield that covers the front and sides of the face) upon entry to the patient room or care area. Gloves -Put on clean, non-sterile gloves upon entry into the patient room or care area. Gowns -Put on a clean isolation gown upon entry into the	F 880	on 8/1/2021. Nurse #9 was provided 1:1 education on 8/2/2021 for Infection Control for Hand Hygiene during dressing changes. NA #8 was provided 1:1 education on 8/3/2021 for proper hand hygiene during meal delivery. Cook #1 and Dietary Aide #1 were provided with 1:1 education on 8/1/2021. 2. All residents have the potential to be affected by this deficient practice. 3. A root cause analysis was completed by Director of Nursing, Infection Preventionist, Regional Nurse Consultant and QAPI (Quality Assurance Performance Improvement) Committee and Governing Body on 9/2/2021. This root cause analysis was incorporated into the facility intervention plan. Beginning on 9/3/2021 completion date of 9/20/2021, all staff including any contract or agency staff will be educated on recommended Personal Protective Equipment (PPE) for residents on Enhanced Droplet Precautions by the Director of Nursing, Assistant Director of Nursing and Executive Director. This education utilized the CDC video Utilizing PPE Correctly; What you need to know about Handwashing and the facility□s COVID-19 Response Guidelines to include recommended PPE for residents on Enhanced Droplet Precautions. Additional Education was provided utilizing facility policy on Transmission Based Precautions, Procedures for Infection Control with dressing changes	

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F 880	Continued From page 119 patient room or area. Change the gown if it becomes soiled. Remove and discard the gown in a dedicated container for waste or linen before leaving the patient room or care area. 1. An observation of the open door of Room #1 on 08/01/21 at 10:57 AM revealed a sign stating Resident # 309 was on Enhanced Droplet Isolation and any person entering the room was to wear an N-95 mask, perform hand hygiene, put on eye protection, put on a gown, and put on gloves before entering the room. Housekeeper #1 was observed at the same date and time to be standing in front of Room #1 with her housekeeping cart wearing only a surgical mask. An interview with Housekeeper #1 on 08/01/21 at 10:58 AM revealed she had just finished mopping under Resident #309's feet due to Resident #309 reporting the floor was sticky under her feet. Housekeeper #1 stated she only wore a surgical mask and gloves while mopping Resident #1's room. She explained she had been trained to use an N-95 mask, goggles, a gown, and gloves before entering any room with an Enhanced Droplet Isolation sign in place but all she had readily available was the surgical mask she had been wearing since the beginning of her shift and gloves from her housekeeping cart. She explained there were usually N-95 masks, goggles, gowns, and gloves on a cart in the hall but she did not see a cart with those supplies and she was afraid Resident #309 might stand up and fall because the floor was sticky so she went ahead and mopped the floor wearing only her surgical mask and gloves. An interview with Nurse #3 on 08/01/21 at 11:14 AM revealed Resident #309 was on Enhanced	F 880	and Hand Hygiene during meal delivery. Education will be provided to staff through multiple avenues including but not limited to verbal, written and telephonically dependent on the staff members availability. Education will be added to the New Hire Orientation on 9/3/2021. An attestation statement will be completed by the Director of Nursing to attest education was completed on 9/20/2021. After 9/20/2021, no staff will be allowed to work until education is completed. Administrative staff (Executive Director, Director of Nursing, and Infection Preventionist) will monitor staff knowledge of Transmission based precautions and recommended PPE for Enhanced Droplet precautions by performing random staff interviews of 3 staff 3 times weekly x 6 weeks for a total of 9 staff then 4 staff weekly x 6 weeks. These interviews will be conducted across all shifts. Administrative staff (Executive Director, Director of Nursing, and Infection Preventionist) will conduct Personal Protective Equipment Audits to ensure Transmission Based Precautions are maintained by performing random observations of donning and doffing PPE across all shifts of 3 staff 3 times weekly x 6 weeks for a total of 9 staff then 4 staff weekly x 6 weeks Administrative staff (Executive Director, Director of Nursing, and Infection Preventionist) will complete observations	

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F 880	Continued From page 120 Droplet Isolation because she was a new admission and any person entering Room #1 was to put on PPE including an N-95 mask, goggles, a gown, and gloves before entering the room. Nurse #3 stated carts containing needed Personal Protective Equipment (PPE) were usually in the halls and there was probably a cart farther up the hall on the other side of the building. An interview with the Director of Nursing (DON) on 08/01/21 at 03:42 PM revealed all newly admitted residents who were not vaccinated or had an unknown vaccination status were placed on Enhanced Droplet Precautions for 14 days and any person entering a resident room with a sign indicating that type of isolation should be wearing the PPE described on the sign. An interview with the Housekeeping Supervisor on 08/05/21 at 01:37 PM revealed housekeeping personnel were expected to wear the PPE described on posted signage when working in isolation rooms. The Housekeeping Supervisor stated she had done in-services with housekeeping staff on what PPE to wear in isolation rooms and where to obtain additional PPE supplies if supplies ran out. She stated the housekeeping department was also included in facility in-services regarding PPE use in isolation rooms. An interview with the Administrator on 08/05/21 at 06:15 PM revealed Resident #309's vaccination status was unknown at the time of admission and that's why she was placed on Enhanced Droplet Precautions. She further stated the facility had plenty of PPE supplies and all staff entering isolation rooms should be wearing the type of	F 880	of Licensed nurses performing dressing changes of 5 residents with dressing changes per week x 12 weeks. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Person Responsible: Administrator and Director of Nursing Date of compliance is 9/20/2021	

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PPE indicated on the sign.

2. Review of the facility's policy titled Isolation-Categories of Transmission-Based Precautions" last updated 01/2018 read in part: "Transmission-Based Precautions are initiated when a resident develops signs and symptoms of a transmissible infection or has a laboratory confirmed infection and is at risk of transmitting the infection to other residents. When a resident is placed on transmission-based precautions, appropriate notification is placed on the room entrance door so that personnel and visitors are aware of the need for and the type of precautions. Contact precautions may be implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. The individual on contact precautions will be placed in a private room if possible".

Review of the quarterly Minimum Data Set (MDS) dated 04/21/21 revealed Resident #22 had an indwelling catheter (a tube that drains urine out of the bladder).

A urine culture (a test to see if bacteria are growing in the urine) dated 07/29/21 revealed Resident #22 was growing Escherichia coli (abbreviated as E-coli and meaning a type of bacteria) extended spectrum beta lactamase (Abbreviated as ESBL and meaning an enzyme which makes treating bacteria with antibiotics more difficult. ESBL bacteria can be spread from person to person on the contaminated hands of residents and caregivers. Transmission risk can be increased if the person has a catheter).

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An observation of the door to Resident #22's room on 08/01/21 at 12:30 PM revealed no posted signage indicating Resident #22 was on isolation.

An interview with Nurse #3 on 08/01/21 at 12:36 PM revealed Resident #22 had been moved to her current room on 07/30/21 so she could have a private room and would not have to share a bathroom with other residents due to ESBL in her urine. Nurse #3 stated she hadn't noticed there was no isolation sign on Resident #22's door. She stated carts containing needed Personal Protective Equipment (PPE) were usually in the halls and there was probably a cart farther up the hall on the other side of the building.

An observation of the door to Resident #22's room on 08/01/21 at 01:08 PM revealed no signage was posted indicating Resident #22 was on isolation.

An interview with Unit Manager #1 on 08/01/21 at 03:17 PM revealed Resident #22 had been moved to her current room on 07/30/21 so she could have a private bathroom due to growing ESBL in her urine. Unit Manager #1 stated Resident #22 should have had an isolation sign posted on her door when she was moved to a private room on 07/30/21 and she thought the Staff Development Coordinator (SDC) was responsible for placing the appropriate isolation sign on Resident #22's door. She explained the SDC was not working on 08/01/21 and was not sure why an isolation sign was not posted on Resident #22's door on 08/01/21. Unit Manager #1 stated she was not sure which type of isolation Resident #22 should have been placed on after

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	345489	A. BUILDING _____ B. WING _____	C 08/13/2021

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her urine culture results returned.

An observation of the door to Resident #22's room on 08/01/21 at 03:28 PM revealed no isolation sign was posted on her door.

An interview with the Director of Nursing (DON) on 08/01/21 at 03:42 PM revealed Resident #22 should have had a sign on her door indicating she was on Contact Isolation. She explained Contact Isolation meant any person entering Resident #22's room should wear a gown and gloves before entering and discard the gown and gloves and perform hand hygiene before leaving the room. The DON stated the isolation sign should have been placed on her door when she was moved a private room on 07/30/21. She stated the nurse on the hall, unit managers, or herself could have placed the Contact Isolation sign on the door of Resident #22's room when she was moved and was not sure why a Contact Isolation sign had not been placed on her door.

An interview with the Administrator on 08/05/21 at 06:15 PM revealed a Contact Isolation sign should have been placed on the door to Resident #22's room when she was moved to the private room and the reason it was not was due to human error.

An interview with the Physician on 08/06/21 at 09:26 AM revealed Resident #22 should have been placed on Contact Isolation when she was diagnosed with ESBL growing in her urine.

3. Review of the facility's policy titled "Procedure: Infection Control Precautions for Dressing Changes, Clean Procedures, and Using the Treatment Cart" last updated in 2019 read in part

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"as soon as you have finished removing the soiled dressing and cleansing the wound, remove and discard your gloves. Wash your hands (or use an alcohol cleanser) after removing and discarding the existing dressing."

A continuous observation of Nurse #9 on 08/02/21 at 02:15 PM revealed she applied betadine to Resident #44's right heel, discarded soiled gloves, and applied clean gloves without performing hand hygiene after removing soiled gloves. Nurse #9 cleaned the wound to Resident #44's right calf, applied dakin's soaked gauze, covered the wound with a dry dressing, and removed soiled gloves. Nurse #9 then applied clean gloves without performing hand hygiene after removing soiled gloves, and removed the dressings to Resident #44's left and right ischium and sacrum. She cleaned the wounds and removed soiled gloves. Nurse #9 applied gloves without performing hand hygiene after removing soiled gloves, packed the left and right ischial wounds. She removed her soiled gloves and reapplied clean gloves without performing hand hygiene in between removing soiled gloves and applying clean gloves, packed the sacral wound, and covered the left and right ischial and sacral wounds with a dry dressing.

An interview with Nurse #9 on 08/02/21 at 03:56 PM revealed she should have performed hand hygiene after removing soiled gloves and before applying clean gloves and she did not perform hand hygiene because it was an oversight.

An interview with the Administrator on 08/05/21 at 06:15 PM revealed staff should always perform hand hygiene after removing soiled gloves and before applying clean gloves.

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A facility education titled "COVID update, Infection Control, PPE (personal protective equipment), Handwashing, and Mask Wearing Correctly", on 7/27/2021 was reviewed.

CDC guidance titled "How to Wear Masks", dated 6/11/2021 was reviewed. It read in part: Put the mask over your nose and mouth and secure it under your chin.

4. An observation was completed on 8/3/2021 at 12:53 PM of Nurse Aide #8 delivering a lunch meal tray to Room 265A without proper hand hygiene. She was observed opening condiments and then opened a sandwich contained in plastic wrap with her bare hands. Nurse Aide #8 then put the contents of the condiment packets on either side of the open sandwich, opened the silverware pouch and cut the sandwich with a knife. She put a straw in a beverage then washed her hands in bathroom. An interview was completed with Nurse Aide #8 at the time of the observation. She explained she washed her hands in the break room before passing out any trays on the hall. She stated she could not provide a reason why she did not perform hand hygiene in between resident meal trays.

Review of Nurse Aide #8's education record revealed she received training on 7/27/2021 related to hand hygiene.

An interview was completed on 8/5/2021 at 9:09 AM with the Administrator, who also served as one of the Infection Preventionists. She stated hand hygiene should be performed before serving or when touching items on meal trays.

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5. An observation of the Dietary Department was completed on 8/1/2021 at 12:48 PM which revealed two (2) dietary staff not wearing face masks covering their nose and mouth while working in the kitchen. Cook #1 was wearing a soiled face mask below his nose and Dietary Aide (DA) #1's face mask was below her chin. An additional observation on 8/3/21 at 11:05 AM of DA #1 was completed of her face mask below her nose.

A phone interview was completed with Cook #1 on 8/3/2021 at 5:00 PM. He explained his mask comes down and he tries to keep it up, but it gets hot in the kitchen. He revealed he had been trained on infection control and Covid-19 inclusive of wearing a mask at all times.

Review of Cook #1's education record revealed he received training on 7/27/2021 related to mask usage.

A phone interview was completed on 8/5/2021 at 11:20 AM with Dietary Aide (DA) #1 who stated she had not received any recent in-person training on infection control and Covid-19 inclusive of wearing a mask at all times. She stated the only infection control training she received was back in March 2020 when COVID was first announced and some online training since then. DA #1 voiced she moved the mask below her nose during tray line when calling out orders to the cook, other than that she wore the face mask properly.

Review of Dietary Aide #1's education record revealed she received training on 7/27/2021 related to mask usage.

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F 880	Continued From page 127 An interview was completed on 8/3/2021 at 1:23 PM with the Dietary Manager (DM) who revealed staff are expected to always have a mask on that covers the nose and mouth. He stated he told DA #1 to cover her nose with her face mask. An interview was completed on 8/5/2021 at 9:09 AM with the Administrator, who also served as one of the Infection Preventionists. She stated face masks should be worn correctly while in the facility.	F 880		