STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345237	A. BUILDING _____ B. WING _____	C 09/09/2021

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BARBOUR COURT NURSING AND REHABILITATION CENTER	515 BARBOUR ROAD SMITHFIELD, NC 27577

(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 000	INITIAL COMMENTS A complaint investigation survey was conducted from 09/07/21 through 09/09/21. Event ID# TC7V11. 10 of the 30 complaint allegations were substantiated resulting in deficiencies.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.	F 550		10/7/21

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

Electronically Signed | 09/27/2021

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F 550	Continued From page 1 §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews, and record review the facility failed to treat residents in a dignified manner by leaving the door open and the privacy curtain in the open position while he was undressed resulting in the resident's exposed body being visible from the hall (Resident #10) and by the use of profanity which resulted in sleep disturbances (Resident #3, Resident #9) for 3 of 4 residents reviewed for dignity. Findings included: 1.Resident #10 was readmitted to the facility on 8/14/2021 with diagnoses that included unspecified dementia without behavior disturbances. The Minimum Data Set (MDS) dated 8/20/2021 revealed Resident #10 was cognitively intact. He required extensive assistance with dressing, had no behaviors, and was always incontinent of bowel and bladder. A continuous observation from 9:30 am through 9:45 am from outside of Resident #10 ' s room on	F 550	Barbour Court Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Barbour Court Nursing and Rehabilitation Center response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Barbour Court Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F550 Resident Rights/Exercise of Rights	

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F 550	Continued From page 2 9/9/2021 revealed he was laying on the bed on his right side with no covering, adult brief, or clothing on. His bed was positioned near the opened door. Resident #14 was sitting on the side of his own bed and faced the front of Resident #10 ' s body. The back of Resident #10 ' s body was exposed from the shoulders down to his feet and he was visible through the opened door. Nurse Aide (NA) #7 and Laundry worker #1 were observed to pass by Resident #10 ' s open door while he was uncovered and exposed. On 9/9/2021 at 9:46 am an interview and observation of Resident #10 were conducted with NA #7. NA #7 confirmed Resident #10 ' s unclothed body was visible from the hallway through the open door. NA #7 then closed the door to the room. During the interview NA #7 stated Resident #10 would not keep his clothing on. She said he has been taking his clothing off for months. NA #7 said she normally closed his door or pulled the curtain, and she did not know why the curtain was not pulled or door closed. During an interview with Nurse #3 on 9/9/2021 at 9:55 am she stated Resident #10 took his clothing off frequently. She stated it was not a certain time of the day that he disrobed. Nurse #3 stated the nurse aides have been told to keep the curtain pulled or the door closed when he was undressed. On 9/9/2021 at 10:00 am during an interview with Resident #10 he stated he took his clothing off all the time. He stated he did not want people to be able to see him without his clothing on. Resident #10 declined to answer any more questions. An interview with Resident #10 ' s roommate on	F 550	On 9/9/21, the Unit Manager assisted resident #10 with donning clothes and pulled privacy curtain to provide privacy for resident. On 9/23/21, the Unit Managers completed an audit of all residents to ensure residents were dressed appropriately and/or provided privacy when dressing or during care. The hall nurse, Unit Managers and/or nursing assistant will address all concerns/preferences identified during the audit to include pulling privacy curtain, closing doors/blinds or assisting residents with care as indicated. On 9/27/21, the Unit managers initiated 100% resident care interactions with all nurses, nursing assistants (NA) to include NA # 1 and #7, therapy staff, housekeeping/laundry staff to include laundry aide #1, accounts receivable, accounts payable, social worker, dietary staff, medical records, maintenance staff, Human Resource Coordinator, Admission Coordinator and activity staff. This interaction is to ensure resident rights are followed to include the right to privacy during care/dressing and the right to be treated with dignity and respect. This includes but not limited to not using profanity in the presence of residents, directed at residents, or within hearing distance of residents and maintaining a quiet environment during resident□s hours of sleep. The Unit Managers and Charge Nurse will address all concerns	

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F 550	Continued From page 3 9/9/2021 at 10:07 am revealed Resident #10 took off his clothing as soon as the staff put the clothing on him. He stated the curtain was not always pulled or the door closed when Resident #10 had no clothing on. An interview with the Director of Nursing (DON) on 9/9/2021 at 12:10 pm revealed staff should have been doing regular checks to make sure Resident #10 was clothed, his door was closed, and/or the privacy curtain was pulled to ensure his unclothed body was not visible from the hall in an effort to maintain his dignity. During an interview with the Administrator on 9/9/2021 at 12:42 pm she stated Resident #10 ' s door should have been closed or the privacy curtain pulled to ensure his unclothed body was not visible from the hall to maintain his dignity. 2.Resident #3 was readmitted to the facility on 1/28/2021 with diagnoses that include diabetes mellitus. The Minimum Data Set dated 7/28/2021 revealed Resident #3 was cognitively intact with adequate hearing without a hearing device. During an interview on 9/7/2021 at 10:30 am Resident #3 stated the nurse aides (NAs) on third shift made a lot of noise when they entered the unit. He stated he was awakened three to four times a week from his sleep from the loud use of profanity by the NAs. He stated this was a regular occurrence since April 2021 and last occurred the last weekend of August 2021. Resident #3 further stated he had trouble going to sleep and did not want to be awakened by the noise. He stated he reported the noise level on third shift	F 550	identified during the interactions to include education of staff. Resident Care Interactions will be completed by 10/7/21. On 9/24/21, the Unit Managers initiated an in-service with all staff nurses, nursing assistants (NA) to include NA # 1 and #7, therapy staff, housekeeping/laundry staff to include laundry aide #1, accounts receivable, accounts payable, social worker, dietary staff, medical records, maintenance staff, Human Resource Coordinator, Admission Coordinator and activity staff in regards to Resident Rights. Emphasis is on the resident□s right to be treated with dignity and respect and the right to privacy. In-service will be completed by 10/7/21. All newly hired nurses; nursing assistants, therapy staff, housekeeping/laundry staff, accounts receivable, accounts payable, social worker, dietary staff, medical records, maintenance staff, Human Resource Coordinator, Admission Coordinator and activity staff will be in-serviced during orientation concerning Resident Rights. The Unit Managers and Charge Nurses will completed 10 Staff to resident care interactions to include resident #10 utilizing the Resident Rights Audit Tool weekly x 4 weeks then monthly x 1 month. This audit is to ensure resident rights are followed to include the right to privacy during care/dressing. The Unit Managers and Charge Nurses will address all concerns identified during the audit to include providing privacy when indicated and re-education of staff. The DON will	

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F 550	Continued From page 4 multiple times to different nurses. Resident #3 stated he reported to agency nurses and they changed all the time. During an interview with NA #1 on 9/9/2021 at 11:00 am she stated she worked third shift mainly on the weekends. She said the NAs used loud profanity all the time on the weekends. She stated she witnessed the loud profanity within the last month (August 2021). NA #1 stated the loud conversations occurred at the 100-hall nursing station. She said she did not report it to anyone. During an interview with the Director of Nursing on 9/9/2021 at 12:10 pm she stated she was not informed that loud profanity was used on third shift. She said the residents should not have been disturbed by profanity while sleeping. On 9/9/2021 at 12:42 pm during an interview the Administrator she stated the nurse management team should have observed and educated the staff about conversations with coworkers. She stated she expected that leadership would come in on third shift and do spot checks. 3. Resident #9 was readmitted to the facility on 7/19/2021 with diagnoses that included anxiety disorder. The Minimum Data Set dated 7/25/2021 revealed Resident #9 was cognitively intact with adequate hearing without a hearing device. An interview conducted on 9/8/2021 at 10:00 am revealed she was often awakened by the NAs loud use of profanity on the third shift. She stated she was awakened by the noise at least two to three times a week. Resident #9 said she knew it	F 550	review the Resident Rights Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The Social Worker will complete five (5) resident interviews with alert and oriented residents to include resident #3 and #9 utilizing Resident Questionnaire-Resident Rights. This interview is to identify any concerns related to the noise level during hours of sleep and/or staff use of profanity in the facility. The Social Workers will address all areas of concern identified during the interviews. The Administrator will review all resident interviews to ensure all concerns were addressed. The Administrator will present the findings of the Resident Rights Audit Tool and Resident Questionnaire-Resident Rights to the Executive Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The Executive QAPI Committee will meet monthly for 2 months and review the Resident Rights Audit Tool and Resident Questionnaire-Resident Rights to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

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F 550	Continued From page 5 was reported by the resident council in April 2021, but the loud profanity continued to occur. Resident #9 said it occurred all the time, so she did not try to keep up with the dates .She stated the foul language really bothered her because she did not use that kind of language and was not use to it. During an interview with NA #1 on 9/9/2021 at 11:00 am she stated she worked third shift mainly on the weekends. She said the NAs used loud profanity all the time on the weekends. She stated she witnessed the loud profanity within the last month (August 2021). NA #1 stated the loud conversations occurred at the 100-hall nursing station. She said she did not report it to anyone. During an interview with the Director of Nursing on 9/9/2021 at 12:10 pm she stated she was not informed that loud profanity was being used on third shift. She said the residents should not be disturbed by profanity while sleeping. On 9/9/2021 at 12:42 pm during an interview the Administrator she stated the nurse management team should have observed and educated the staff about conversations with coworkers. She stated she expected that leadership would come in on third shift and do spot checks .	F 550		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced	F 677		10/7/21

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F 677	Continued From page 6 by: Based on staff interviews and record review the facility failed to provide incontinence care for 2 of 5 residents reviewed for activities of daily living care (Resident #1, and Resident #2). Findings included: 1. Resident #1 was admitted to the facility on 7/20/16. Her active diagnoses included myocardial infarction, anemia, coronary artery disease, hypertension, hyperlipidemia, and dementia. Resident #1's quarterly minimum data set assessment dated 7/1/21 revealed she was assessed as moderately cognitively impaired. She had no behaviors and required extensive two person assistance with bed mobility and dressing. She required extensive one person assistance with personal hygiene. She was totally dependent on two staff for transfers, toilet use, and bathing. She was always incontinent of bowel and bladder. She had no pressure ulcers. Resident #1's care plan dated 7/17/21 revealed she was care planned to require assistance with activities of daily living. The interventions included to use incontinent products and provide frequent toileting. During an interview on 9/7/21 at 9:37 AM Nurse #1 stated Resident #1 needed help with a bath in morning and when he entered, he saw that her brief, pad, and bedsheets were soaked with urine. Nurse Aide #2 was the nurse aide who was assisting with morning activities of daily living care for Resident #1. Nurse #1 stated he could not remember the date, but it was a few weeks	F 677	F677 ADL Care Provided for Dependent Residents On 9/22/21, the Unit Managers assessed resident #1 and resident #2 to ensure incontinent care had been provided timely. There were no concerns identified. On 9/22/21, the Unit Managers initiated an audit of all incontinent resident to ensure residents were provided incontinent care timely. The Unit Managers addressed all concerns identified during the audit to include providing incontinent care and education of the staff. Audit will be completed by 10/7/21. On 9/24/21, the Unit Managers initiated an in-service with all nurses and nursing assistants in regards to Incontinent Care with emphasis on providing incontinent care timely. In-service will be completed by 10/7/21. All newly hired nurses and nursing assistants will be in-serviced during orientation in regards to Incontinent Care. The Unit Managers and Charge Nurses will complete 15 Resident Care Incontinent Audits on residents who are incontinent to include resident #1 weekly x 4 weeks then monthly x 1 month. (Resident #2 no longer resides in facility). Audits will include all shifts and all days of the week. This audit is to ensure all residents with incontinence are provided incontinent care timely. The Unit Managers and the Charge Nurses will	

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F 677	Continued From page 7 ago. During an interview on 9/7/21 at 10:52 AM Nurse Aide #1 stated she and Nurse Aide #5 had to take care of all the residents except for the Alzheimer's unit one night shift a week or two ago but could not remember the exact date. She stated once they knew it was just the two of them, they started their rounds, and it took from about 11:30 AM to 4 AM to complete their first round. She stated she was unable to provide timely activities of daily living care to all residents because they had so many residents on their shift. She stated she could not remember the nurses who were working that night but believed they were agency, and they did not help or call anyone for assistance when they let the nurses know they were short of help. She stated her and the other nurse aide started work right away and did not have a chance to call for help either. She further stated she was sure there were residents who were soaked through as she did not have enough time to get to them during the entirety of her shift and because she did not get to them, she did not know who she had missed but knew there had been residents who were missed for activities of daily living care. She stated it was a devastating night and was just impossible to provide care to all the residents. She concluded she could not remember the exact census number, but it was approximately 148 residents split between the two of them and they rounded together because some residents needed two person assistance with activities of daily living. She concluded staffing on night shift was a continual problem and she did not know why they were unable to keep staff and why staff would simply not show up for work some nights.	F 677	address all concerns identified during the audit to include providing incontinent care when indicated and re-education of the staff. The Director of Nursing will review the Resident Care Incontinent Audits to ensure all areas of concern were addressed. The Administrator will present the findings of the Resident Care Incontinent Audits to the Executive Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The Executive QAPI Committee will meet monthly for 2 months and review the Resident Care Incontinent Audits to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

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During an interview on 9/7/21 at 12:10 PM Nurse Aide #2 stated staffing had been going down in the facility and was an ongoing problem. She stated she remembered one morning but could not remember the date, when she came to the facility and Resident #1 was soaked through her brief, pad, gown, and sheets. Nurse #1 had to help her with the morning care that day. She stated this had occurred off and on for the past few months, but she could remember this time in particular and who the resident was. She stated also sometimes when she came in to work, she found the resident had double briefs on. She stated she had spoken with Unit Manager #1 about the concern of residents not receiving care at night due to staffing and Unit Manager #1 had told her she would speak with the Director of Nursing and they would see what they could do.

During an interview on 9/7/21 at 4:20 PM Unit Manager #1 stated she could not remember the exact date, but she came in the next day and was made aware that Nurse Aide #1 and Nurse Aide #5 had been the only nurse aides outside of the sparks unit and the staff were unable to provide adequate care. She stated she remembered Nurse Aide #2 came to her and spoke to her about residents being left soaked from the night shift and she told the staff that the night shift was very challenged due to staff not showing up for their scheduled times.

During an interview on 9/8/21 at 9:18 AM the Director of Nursing stated she knew at one point the administrator told her there were only two nurse aides who worked outside of the locked unit for the night. She stated she was unsure of what the date was and the nurses were agency that night and no staff members notified anyone

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of the fact there were so few staff in the building. She stated when she arrived in the morning, she would be made aware by staff that there had not been enough staff in the building the night before to provide activities of daily living care. She stated the worst night this happened was the night when only Nurse Aide #1 and Nurse Aide #5 worked the night shift. She stated she had no answer for why staff were not notifying administration of staff shortages and was aware activities of daily living care not being provided due to staff being short from call outs and no call no shows was an issue.

During an interview on 9/8/21 at 9:45 AM the Administrator stated it was not until the next day she was informed that there had been only three nurse aides in the building during one 11 PM to 7 AM shift a few weeks ago. She could not remember the date it happened. She stated 1 nurse aide was in the locked unit and the other two nurse aides took care of the rest of the facility. She stated three nurse aides for the building on 11 PM to 7 AM shift did not meet her staffing expectations and was not adequate staff to provide activities of daily living care.

During an interview on 9/9/21 at 8:59 AM Nurse Aide #5 stated she did not remember the exact date, but it was about two weeks ago when her and Nurse Aide #1 had the entire facility except the locked unit on their workload during the 11 PM to 7 AM shift. She stated she was unable to provide activities of daily living care to all residents because there were just too many residents to care for on their shift. She stated she did not remember the exact census, but it was probably around fifty residents for her and fifty residents for Nurse Aide #1. She stated that was just too many residents to be able to get to

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everyone and provide activities of daily living care, so she was sure that there were residents who did not receive any care that night. She stated because she was unable to get to everyone, she did not remember specifically which residents did or did not receive care. She stated they notified the nurses, who were agency nurses, and she could not remember who they were, but the nurses did not call administration to get any help and did not help the nurse aides with care. She further stated not having enough staff in the building on 11 PM to 7 AM shift was a common problem. She stated activities of daily living care would be missed on night shift and must be picked up by the morning shift due to continuing staffing issues.

2. Resident #2 was admitted to the facility on 8/14/2020. Her active diagnoses included heart failure, hypertension, and chronic pain.

Resident #2's annual minimum data set assessment dated 7/15/21 revealed she was assessed a severely cognitively impaired. She had no behaviors and was totally dependent on two staff for bed mobility, transfers, toilet use, and personal hygiene. She required extensive assistance from two staff for dressing. She was always incontinent of bowel and bladder. She had no pressure ulcer.

Resident #2's care plan dated 7/16/21 revealed she was care planned to require assistance with activities of daily living. The interventions included to provide pericare after each incontinent episode.

Per the facility assessment tool dated 7/20/21 revealed the facility had an average daily census

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of 131 residents in the facility.

During an interview on 9/7/21 at 9:44 AM Nurse #2 stated staffing for the night shift had been a challenge. She stated she believed it was last week but could not remember the date, that she went to help Nurse Aide #6 on first shift with Resident #2's morning care and the pad, bed, gown, and the brief of Resident #2 was soaked with urine. She stated they had to change everything to clean the resident and wipe down the mattress. She stated based on the amount of urine, the resident had not received activities of daily living care through the entire night shift from 11 PM to 7 AM. She stated she believed this happened because there was one nurse aide for about fifty residents during the night shift prior to her shift that day. There were only three nurse aides in the entire building that night, but one was only in the locked unit so one had one side and the other had the other side of the skilled nursing unit. She concluded everyone was aware of the staffing issues.

During an interview on 9/7/21 at 10:52 AM Nurse Aide #1 stated she and Nurse Aide #5 had to take care of all the residents except for the Alzheimer's unit one night shift a week or two ago but could not remember the exact date. She stated once they knew it was just the two of them, they started their rounds, and it took from about 11:30 AM to 4 AM to complete their first round. She stated she was unable to provide timely activities of daily living care to all residents because they had so many residents on their shift. She stated she could not remember the nurses who were working that night but believed they were agency, and they did not help or call anyone for assistance when they let the nurses know they

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were short of help. She stated her and the other nurse aide started work right away and did not have a chance to call for help either. She further stated she was sure there were residents who were soaked through as she did not have enough time to get to them during the entirety of her shift and because she did not get to them, she did not know who she had missed but knew there had been residents who were missed for activities of daily living care. She stated it was a devastating night and was just impossible to provide care to all the residents. She concluded she could not remember the exact census number, but it was approximately 148 residents split between the two of them and they rounded together because some residents needed two person assistance with activities of daily living. She concluded staff on night shift was a continual problem and she did not know why they were unable to keep staff and why staff would simply not show up for work some nights.

During an interview on 9/7/21 at 12:00 PM Nurse Aide #6 stated the facility had issues with staffing in the facility and were short staffed. She stated one night she remembered a few weeks ago she did come to the facility for her day shift from 7 AM to 3 PM and there had only been two nurse aides working that night. She could not remember the exact date or the census; however, she remembered Resident #2 was observed to have urine soaked through the resident's brief and soaked the pad, gown, and sheets of Resident #2. She stated the nurse helped her get the resident cleaned and it was apparent to both her and the nurse that because there were only two nurse aides on the skilled side of the building during the night shift, care had not been provided to Resident #2 for a very long time. She stated

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staffing was an ongoing issue in the facility, but this was the one example that stuck out which she could remember specifically.

During an interview on 9/7/21 at 4:20 PM Unit Manager #1 stated she could not remember the exact date, but she came in the next day and was made aware that Nurse Aide #1 and Nurse Aide #5 had been the only nurse aides outside of the sparks unit and the staff were unable to provide adequate care. She stated she remembered Nurse Aide #2 came to her and spoke to her about residents being left soaked from the night shift and she told the staff that the night shift was very challenged due to staff not showing up for their scheduled times.

During an interview on 9/8/21 at 9:18 AM the Director of Nursing stated she knew at one point the administrator told her there were only two nurse aides who worked outside of the locked unit for the night. She stated she was unsure of what the date was and the nurses were agency that night and no staff members notified anyone of the fact there were so few staff in the building. She stated when she arrived in the morning, she would be made aware by staff that there had not been enough staff in the building the night before to provide activities of daily living care. She stated the worst night this happened was the night when only Nurse Aide #1 and Nurse Aide #5 worked the night shift. She stated she had no answer why staff were not notifying administration of staff shortages and was aware activities of daily living care not being provided due to staff being short from call outs and no call no shows was an issue.

During an interview on 9/8/21 at 9:45 AM the Administrator stated it was not until the next day

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she was informed that there had been only three nurse aides in the building one 11 PM to 7 AM shift a few weeks ago. She could not remember the date it happened. She stated 1 nurse aide was in the locked unit and the other two nurse aides took care of the rest of the facility. She stated three nurse aides for the building on 11 PM to 7 AM shift did not meet her staffing expectations and was not adequate staff to provide activities of daily living care.

During an interview on 9/9/21 at 8:59 AM Nurse Aide #5 stated she did not remember the exact date, but it was about two weeks ago when her and Nurse Aide #1 had the entire facility except the locked unit on their workload from 11 PM to 7 AM shift. She stated she was unable to provide activities of daily living care to all residents because there were just too many residents to care for on their shift. She stated she did not remember the exact census, but it was probably around fifty residents for her and fifty residents for Nurse Aide #1. She stated that was just too many residents to be able to get to everyone and provide activities of daily living care, so she was sure that there were residents who did not receive any care that night. She stated because she was unable to get to everyone, she did not remember specifically which residents did or did not receive care. She stated they notified the nurses who were agency nurses, and she could not remember who they were, but the nurses did not call administration to get any help and did not help the nurse aides with care. She further stated not having enough staff in the building on 11 PM to 7 AM shift was a common problem. She stated activities of daily living care would be missed on night shift and must be picked up by the morning shift due to continuing staffing issues.

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F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to provide nail care or arrange podiatry services for 1 of 3 residents (Resident #12) reviewed for foot care. Findings included: Resident #12 was admitted to the facility on 08/18/2020 with diagnoses including type 2 diabetes mellitus and dementia. A review of the quarterly minimum data set assessment (MDS) for Resident #12 dated 07/27/2021 revealed she was severely impaired for daily decision making. Resident #12 had no behaviors or rejection of care during the assessment period. She required total assistance of one person for bathing and extensive assistance of one person for personal hygiene. A care plan focus area for Resident #12 initiated on 08/19/2020 of activities of daily living and personal care revealed a goal of activities of daily	F 687	F687 Foot Care Resident #12 was scheduled an appointment with Podiatry on 9/30/21at 2:15 pm. On 9/22/21, the Unit Managers initiated a 100% audit of resident nails to include resident #12. This audit is to ensure nail care to include toenails was provided per resident preference and/ or podiatry services consult initiated when indicated. The Unit Managers addressed all concerns identified during the audit to include trimming nails per resident preference and initiating podiatry services when indicated. Audit will be completed by 10/7/21. On 9/24/21, the Unit Managers initiated an in-service with all nurses to include nurse #3 and nursing assistants (NA) to include NA #7 in regards to Nail Care. Emphasis	10/7/21

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F 687	Continued From page 16 living and personal care will be completed with staff support as appropriate to maintain or achieve highest practical level of functioning through the next review. Interventions included aid with bathing, personal hygiene, and grooming. On 09/09/2021 at 10:13 AM during a bathing activity Resident #12's toenails on both feet were observed to be thick and long, extending approximately ¼ inch beyond the nail bed. The nails of her great toes were observed to be approximately ¼ to ½ inch long, thick, and curved downward. On 09/09/2021 at 10:36 AM during an interview Nurse #3 stated Resident #12's toenails were thick and long, extending approximately ¼ inch beyond the nail bed. She stated they were unacceptable. She further indicated Resident #12's toenails were too thick to be cut by staff and Resident #12 would need to see a podiatrist. She went on to say nursing assistants (NA) were responsible for clipping resident's toenails during bathing activity. Nurse #3 stated if NA's were unable to cut a residents toenails, they were supposed to notify the nurse. She stated no one had ever notified her of any issues with Resident #12's toenails. On 09/09/2021 at 10:44 PM an interview with Resident #12's social worker (SW) indicated a podiatrist came to the facility quarterly. He stated a podiatrist last visited the facility in July 2021. He went on to say nurses would let him know which residents needed to be seen and he would send the list to the podiatrist. He stated he had never added Resident #12 to any podiatry list because no one had ever let him know Resident #12 needed to be seen.	F 687	on providing nail care per resident preference and initiating podiatry services consult when indicated. In-service will be completed by 10/7/21. All newly hired nurses and nursing assistants will be in-serviced during orientation in regards to Nail Care. The Unit Managers, treatment nurses and Charge Nurse will complete an audit of 15 resident□s nail/foot care to include nail care for resident #12 weekly x 4 weeks then monthly x 1 month utilizing the Nail Care Audit Tool. This audit is to ensure nail care to include toenails was provided per resident preference and/ or podiatry services consult initiated when indicated. The Unit Managers will address all concerns identified during the audit to include trimming nails per resident preference and initiating podiatry services when indicated. The Director of Nursing will review the Nail Care Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The Administrator will present the findings of the Nail Care Audit Tool to the Executive Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The Executive QAPI Committee will meet monthly for 2 months and review the Nail Care Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

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F 687	Continued From page 17 A review of the facility podiatry list for July 2021 revealed Resident #12 was not on the list and had not been seen. A review of Resident #12's medical record revealed no evidence she had been seen by a podiatrist since her admission to the facility. On 09/09/2021 at 12:58 PM a telephone interview with NA #7 indicated she provided Resident #12 with a full bath on 08/31/2021. She stated she noticed Resident #12's toenails were long and thick and needed cutting, but she had not been able to cut them. She went on to say she thought she had reported this to Nurse #4. On 09/09/2021 at 1:59 PM a telephone interview with Nurse #4 indicated he did not recall anyone ever reporting to him Resident #12's toenails were long and thick or could not be cut. On 09/09/2021 at 2:18 PM an interview with the director of nursing (DON) indicated Resident #12's toenails were too long and thick for staff in the facility to be able to cut. She stated because Resident #12 was a diabetic, she should have been added to the podiatry list upon her admission to the facility. She stated Resident #12 had not been added to the list of residents needing podiatry services on her admission to the facility and there was no record of Resident #12 receiving any podiatry services.	F 687		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with	F 725		10/7/21

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F 725	Continued From page 18 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 by: Based on record review and staff interviews the facility failed to provide sufficient nursing staff to provide incontinence care to residents who were soiled with urine (Resident #1 and Resident #2) for 2 of 5 residents reviewed for staffing. Findings included: This tag is cross referenced to: Tag F677 - Based on staff interviews and record review the facility failed to provide incontinence	F 725	F725 Sufficient Nursing Staff On 9/27/2, the Administrator reviewed the assignments sheets for the upcoming 3 days to ensure there are adequate nursing assistant staff scheduled to meet the staffing requirements and needs of the residents. The Administrator and scheduler will address all concerns identified during the audit.	

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F 725	Continued From page 19 care for 2 of 5 residents reviewed for activities of daily living care (Resident #1, and Resident #2). During an interview on 9/7/21 at 4:20 PM Unit Manager #1 stated she was aware there had been issues with 11 to 7 staffing in general. She stated they would have the schedule staffed fully according to the paperwork and then some of the staff would no call and no show. She further stated they never intentionally staffed only three nurse aides in the entire building, but it did happen due to call outs or staff no call no shows. She stated they had shifted from agency to students to be the nurse aides with the waiver. The students were required to be evaluated at a sister facility and have skills check offs before being able to provide care, however the students unfortunately were not showing up for their scheduled shifts. She stated this meant on paper they appeared fully staffed, but there had been multiple occasions where only three nurse aides were physically present in the building. She further stated with only three nurse aides in the building from 11 PM to 7 AM, which is the shift these issues were happening on, the staff were unable to provide adequate care. She stated her and the Director of Nursing had spoken about the issues with staffing and the Administrator had stated there should never be only three nurse aides working on night shift alone. She stated she believed with their current budget there should be 7 to 8 nurse aides on night shift from 11 to 7. She further stated this issue has been ongoing and had not been resolved. She further stated staff were only on call Friday, Saturday, and Sunday night. She further stated the nurses and nurse aides could have called the Director of Nursing to inform her of the staffing issues but was not aware of anyone calling. She concluded there	F 725	On 9/27/21, The administrator reviewed agency contracts to ensure the facility has multiple agencies to choose from during staff concerns. The purpose of the agency service is to fill open on duty aide positions to meet staffing requirements and meet the needs of the residents. The facility is utilizing Florence, Favorite, Excel, Allegiance, Cornerstone and Maxim. To ensure availability of contracted staff, the facility has additionally reviewed contract staff assignments in place of prn agency staffing when available. The facility has consistently been placing ads on Indeed for posting of job openings. The advertisements for nursing assistants and/or nurse assistant trainees have consistently been running since February 2021. The ads are re-initiated every 14-21 days. On 10/4/21, the scheduler will begin validating nursing assistant staff schedule 24 hours prior to schedule shift to ensure staff schedule is accurate and to confirm staff attendance. The scheduler will notify the Director of Nursing and/or Administrator of all staffing concerns. On 10/4/21, the Unit Managers and/or Assistant Director of Nursing will confirm staff attendance each shift to ensure the facility has at least the minimum requirements to provide personal care and supervision according to local state and federal regulations and codes. The Unit Manager and/or Assistant Director of	

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F 725	Continued From page 20 had been no education to her knowledge of staff to call when their staffing was short. During an interview on 9/8/21 at 9:18 AM the Director of Nursing stated due to the pandemic staffing across the board and especially 11 PM to 7 AM shift had been an issue with staff no call no shows. The staff in the building when no call no shows happened were then not notify administration about the concern that there was not enough staff in the building. She stated when she arrived in the morning, she would be made aware by staff that there had not been enough staff in the building the night before to provide timely activities of daily living care. She stated she had no answer why staff were not notifying administration of staff shortages and was aware this was an ongoing issue with staffing as well as activities of daily living care not being provided due to staff being short from call outs and no call no shows. She stated they would give staff a warning for not notifying the facility timely that they could not cover their shift. If the staff member continued to no call no show, they would terminate the staff. She stated it had gotten better since that one day as far as activities of daily living care. During an interview on 9/8/21 at 9:45 AM the Administrator stated three nurse aides for the building on 11 PM to 7 AM shift did not meet her staffing expectations. She stated she was not notified until the next morning. She stated once informed of staffing concerns, the nurse should reach out to administration for assistance. She stated the nurse aides were doing everything they could and followed chain of command and notified the nurses of the lack of staff. She stated no one from administration was made aware of	F 725	Nursing will immediately notify the Director of Nursing and/or Administrator of all staffing concerns. On 9/24/21, the Assistant Director of Nursing initiated an in-service with all nurses and nursing assistants in regards to the new Attendance Policy. Emphasis on expectations on attendance and policy violations. In-service will be completed by 10/7/21. All newly hired nurses and nursing assistants will be in-serviced during orientation in regards to Attendance Policy. On 9/24/21, the Assistant Director of Nursing initiated an in-service with all nurses and nursing assistants in regards to Staffing with emphasis on notification of Manager on Duty, Assistant Director of Nursing, Director of Nursing (DON) and/or Administrator when the facility does not have adequate staff to meet the needs of the residents. In-service will be completed by 10/7/21. All newly hired nurses and nursing assistants will be in-serviced during orientation in regards to Staffing. The Assistant Director of Nursing, DON, and scheduler will review the upcoming schedule and staffing assignment sheets for staffing needs weekly x 4 weeks then monthly x 1 month utilizing the Staffing Audit Tool to ensure the facility has minimum requirements to provide personal care and supervision according to local state and federal regulations and codes. The scheduler will ensure that off duty staff and/or agency are contacted	

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F 725	Continued From page 21 this issue until the next day and she could not explain why staff did not contact administration about the concern. She stated they reposted phone numbers in the facility for administration contact because agency staff changed regularly, and she had not been able to consistently educate them to contact administration with staffing concerns. She then met with her staff and told them not to rely on the agency nurses to follow facility notification procedures because they might not be fully aware of the procedures. She told her permanent staff that even the nurse aides can contact administration to inform them of any concerns and gave her personal number to the two nurse aides who worked that night. She stated they could even direct scan something from the copy machine to her email that requested the administrator come to the facility. She stated the facility was scheduling the correct number of staff on paper; however, no call no shows were a continual issue with staffing because they would not know that the staff who were scheduled were not showing up for work. On night shift, according to their facility assessment and census, they have 8 nurse aides scheduled for the 11 PM to 7 AM shift and unfortunately with call outs and especially no call no shows from staff and agency staff, they were not always able to have an adequate number of staff.	F 725	when an assignment needs filling. The Administrator will review the Staffing Audit Tool weekly x4 weeks then monthly x 1 month to ensure all concerns addressed. The Administrator will forward the results of the staffing assignment sheets to the Executive Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The Executive Quality Assurance Performance Improvement (QAPI) committee will meet will meet monthly for 2 months and review the Staffing Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	